Weber Behavioral Health

Registration Information

(Please Print)

Date: _____

Client

Name: _____ Sex: __M __F DOB: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone# _____ Cell Phone# _____ Email: _____

Married _____ Widowed _____ Single _____ Minor _____ Separated _____ Divorced _____

Client: Employer/School _____ Phone #: _____

Parent

Name: _____ Sex: __M __F DOB: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone# _____ Cell Phone# _____ Email: _____

Parents: Employer _____ _____ Phone #: _____

Financially Responsible Person: _____ Relationship to client: _____

Guardian

Name: (if different than parent) _____ Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone# _____ Cell Phone# _____ Email: _____

Purpose for visit: _____

Family Members Name/Relationship/Birthdate

_____

_____

_____

_____

Do you have Medical Insurance, Medicaid, or Medicare? _____yes _____no

Insurance:

Name of primary insurance _____ Phone #: _____

ID#: _____ Group/Policy#: _____ Employer: _____

Subscriber: _____ DOB: _____

Name of secondary insurance _____ Phone #: _____

ID#: _____ Group/Policy#: _____ Employer: _____

Subscriber: _____ DOB: _____

Medicaid ID#: _____ Please Circle: Total Care/WellCare/United

Fees:

Diagnostic Assessment:	$250.00
Substance Abuse Evaluation:	$250.00
15 minute Medication Evaluation:	$90.00
10 min Medication Evaluation:	$60.00

I prefer to:
___Pay my balance in full at time of service.
___Pay my balance in full upon receipt of first statement.
___Make payment arrangements prior to services beginning.
___Have the clinic file insurance claims.
___I have either applied for or wish to apply for the sliding fee discount.

In case of emergency, who should be notified? _____ Phone # _____

Weber Behavioral Health has permission to contact the above person in the event of an emergency.

_____Initials

Pharmacy name: _____ City: _____ Phone#: _____

How did you learn about us? _____

Insurance Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Weber Behavioral Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Weber Behavioral Health may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____

Signature of Client or Guardian | If Guardian, Relationship to client | Date

_____ _____

Provider or Witness | Date