Provider Name _____

Dirksen Center for Neurobehavioral Health

___ **AH** ___ **CL** ____ **DF** ___ **FRG**

PATIENT INFORMATION

Last Name_____ First_____MI_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Marital Status_____Date of Birth_____Age_____Sex_____

Soc Sec Num_____Language Preference _____

Race: ___Asian ____ American/Alaskan Indian ____ Black/African American ____ Hawaiian ____Other/Unk ____White ____Declined

Ethnicity: _____Hispanic / Latino _____Non Hispanic /Non Latino _____Declined

Email Address_____ Emergency Contact Name_____

Emergency Contact Phone:_____ Relationship_____

GUARANTOR INFORMATION

WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

Email Address_____

POLICYHOLDER INFORMATION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

	PRIMARY	**SECONDARY**	**OTHER**
INS COMPANY NAME			
POLICY HOLDER NAME			
POLICY NUMBER			
RELATIONSHIP TO PT			
EMPLOYER OF INSURED			

All signatures contained herein apply to services rendered at:

Dirksen Center for Neurobehavioral Health

Informed Consent for Treatment:
I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____Date_____

Relationship to patient (if applicable)_____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third-party payor.
5. I understand that my report and data will not be released until the balance has been paid in full.
6. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name_____ Date_____

Patient OR Guarantor Signature (if patient is a minor)_____

Release of Information:
I give my consent to DCN to release the report and communicate with members of my treatment team and/or referring provider listed below. I also understand that I can revoke my consent for any reason by contacting DCN in writing or speaking with a DCN clinician:

1. Name: _____ Phone: _____ Date:_____

2. Name: _____ Phone: _____ Date:_____

3. Name: _____ Phone: _____ Date:_____

Signature_____ Date_____

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature_____ Date_____