Shorehaven BEHAVIORAL HEALTH, INC

REGISTRATION FORM AND PAYMENT PLAN

Please PRINT. Please fill in this important information as completely as possible. If the client is a *child or adolescent*, put the child's information in the first box. If this is *couples therapy*, in the first box place the name of the person in whose name we are to bill.

Client's Name _____ Sex: M F Date of Birth:____/____/___

Address:_____ City: _____

State/Country: _____ Zip/Postal Code: _____ CLIENT Soc Sec Number (for billing purposes):_____

Hm Phone:(_____)_____ Cell Phone: (_____)_____ I have texting on this number: Y □ N □

Email _____

If working, Employer:_____ Business Phone:_____ Occupation:_____

If this is a couple therapy, the next box is for the partner or spouse.

If the client is a child, the next box is for the parent or legal guardian who insures the child.

CHECK RELATIONSHIP TO THE CLIENT **Spouse/Partner____ Parent____ Guardian____ Foster Parent____**

Name _____ Sex: M F Date of Birth:____/____/___

Address:_____ City: _____

State/Country: _____ Zip/Postal Code: _____ CLIENT Soc Sec Number (for billing purposes):_____

Hm Phone:(_____)_____ Cell Phone: (_____)_____ I have texting on this number: Y □ N □

Email _____

If working, Employer:_____ Business Phone:_____ Occupation:_____

Y N Is patient on disability OR has patient applied for Social Security disability benefits?

Emergency Information: Name of Closest Relative:_____

Relationship:_____ Phone:(_____)_____

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

Insurance and Payment Plan Information

Primary Insurance Plan : We need complete information in order to bill your insurance.

Primary Insurance Company: _____

Subscriber if other than the client: _____ Subscriber Birth date _____

If subscriber is not the client, then we need subscriber's SSN _____

Address, if different from client _____

Group #_____ Subscriber # or billing ID#_____

Insurance Company Phone # _____

Claims Address_____

-Please complete the information on the other side. Please sign this document.

Secondary Insurance Plan : We need complete information in order to bill your insurance.

Secondary Insurance Company: _____

Subscriber if other than the client: _____ Subscriber Birth date _____

If subscriber is not the client, then we need subscriber's SSN _____

Address, if different from client _____

Group #_____ Subscriber # or billing ID#_____

Insurance Company Phone # _____

Claims Address_____

Payment Plan: □ 1. *I will pay the usual and customary fee* by cash, check, or credit card:

(circle) Visa MC Card No._____ Expiration:_____/____

Security Code:_____.

□ 2. *I will submit the bill to my insurance co*. and collect from my insurance. I will pay the usual and customary fee (or negotiated rate) at each session.

□ 3. *SBH will bill my insurance.* I will pay any amounts which the insurance does not, such as deductibles and co-payments, or for which my insurance is not responsible. If insurance benefits are exhausted, I will pay the usual fee. I will pay any co-payments at each visit.

□ 4. Other fee agreement negotiated with therapist using discounted fee scale:_____

□ 5. Medicaid SED In-Home Program or other program which has no co-payments

Payment Plan Agreement. I made this agreement with the understanding that I accept full responsibility and liability for any and all charges incurred and guarantee timely payment of the agreed upon charges. I also understand that I will be liable for any costs associated with collection activities necessitated by delinquent outstanding charges, including costs levied by collection agencies, legal fees, search fees, or other related collection costs. Charges for bounced checks will be $25. SBH may charge interest (1.5%/month) on unpaid balances delinquent commencing one month following a statement being sent to me.

Payment for Missed appointments. If for any reason an appointment cannot be kept, therapist must be notified one day in advance or the customary charge will be due. Missed appointments cannot be billed to insurance.

Authorization to Bill. My signature authorizes Shorehaven Behavioral Health, Inc., (SBH) (1) *to file insurance claims* with my insurer for services provided to patient *without obtaining my signature on each and every claim* to be submitted and (2) *to release any information* needed to process my insurance claims or to collect on my bill and (3) to bill the charge card listed on the payment plan.

Assignment of Benefits. I authorize my insurance carrier to pay, and I assign directly to SBH, all benefits from my insurance for services provided by SBH.

Signature:_____ Date:____/____/_____

(Patient if 14 or over)

Signature:_____ Date:____/____/_____

(Parent, if responsible for payment)

Therapist: 1) Please make sure information is complete. 2) A new Client Insurance Change Notice form is required when the client's primary or secondary insurer changes.