BEHAVIORAL PEDIATRIC AND FAMILY THERAPY PROGRAM

Account # ______________________

Patient Last Name	First	MI	Birthdate	Gender

Street Address/Apt #	City	State	Zip	Best Contact Phone

Only a patient or his/her legal guardian can be the responsible party unless someone else gives their written consent

RESPONSIBLE PARTY'S NAME____
Last Name First MI

Birthdate ______________________ SSN ______________________

Address ______________________ City ____________ State ______ Zip ________

E-Mail Address ______________________ Employer Name ______________________

Cellular Phone ______________ Work Phone ______________ Home Phone ______________

SPOUSE or
OTHER PARENT ______________________________________ Birthdate ______________

Address ______________________ City ____________ State ______ Zip ________

Employer ______________________ Cellular Phone ______________ Work Phone ______________

OTHER ______________________________________ Birthdate ______________
(partner, noncustodial parent, step-parent, or foster parent, etc.)

Address ______________ City __________ State ______ Zip ______ Home Phone ________

Employer ______________________ Cellular Phone ______________ Work Phone ______________

Emergency Contact other than parent or spouse
Name ______________________ Relationship ______________ Phone ______________

PRIMARY INSURANCE COMPANY
Insurance Company ______________________
Policy Holder ______________________
Member ID Number ______________________
Group Number (if any) ______________________

SECONDARY INSURANCE COMPANY
Insurance Company ______________________
Policy Holder ______________________
Member ID Number ______________________
Group Number (if any) ______________________

LIST ALL SIBLINGS OR CHILDREN OF PATIENT STARTING WITH FIRST BORN

NAME	BIRTHDATE	SEX	DIAGNOSIS (FOR OFFICE USE ONLY)

I hereby authorize Behavioral Pediatric and Family Therapy Program to release any information acquired in the course of treatment to my insurance carrier. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments directly to the psychologist/therapist. Pursuant to any applicable provider relations' agreement, I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature ______________________________________ Date ______________