All Patients Must Complete This Section: (Please Print Legibly)

Doctor/Therapist you are here to see_____ Date _____

Patient Legal Name
Legal Last_____Legal First_____ MI_____ Date of Birth: _____

Marital Status_____ Social Security #_____Sex: M F Age _____

Home Phone #_____ Work Phone #_____ Ext. _____

Cell Phone #_____ Email Address: _____

Home Address_____City_____ State_____ Zip _____

Employer Name_____Occupation: _____

Employer Address_____City_____ State_____ Zip_____

Referring MD or Source_____ Referral Phone #_____

Party Responsible for the Bill (if different from the patient)

Legal Last_____Legal First_____Date of Birth_____ Relationship to Patient_____

Home Address_____City_____ State_____ Zip _____

Employer Name_____Work Phone #_____

Employer Address_____City_____ State_____ Zip_____

Spouse Information

Spouse's Legal Name_____ Social Security # _____

Spouse's Cell Phone_____ Date of Birth_____

Spouse's Employer_____Employer Phone #: _____

Primary Insurance_____Policy Holders Legal Name_____

Home Phone_____ Cell Phone_____ Relationship to Patient_____

Insured's Employer_____ Insured's Date of Birth _____

Medicare: Y N Ethnicity (Medicare/Medicaid Only): Caucasian African American Hispanic Asian Other:_____

Members SSN #_____Insurance Phone #_____

Insurance Address_____City_____ State_____ Zip _____

Policy #_____ Group #_____ Effective Date: _____

Secondary Insurance_____Policy Holder _____

Home Phone_____ Cell Phone_____ Relationship to Patient_____

Insured's Employer_____ Insured's Date of Birth _____

Medicare: Y N Ethnicity (Medicare/Medicaid Only): Caucasian African American Hispanic Asian Other:_____

Members SSN #_____Insurance Phone #_____

Insurance Address_____City_____ State_____ Zip _____

Policy #_____ Group #_____ Effective Date: _____

If Accident, Injury or Workers' Comp Related

Is current episode or treatment due to an accident?: Y N Date of Accident _____

If Yes describe: Workers' Comp. Auto Other: _____

Contact Name_____ Members SSN #:_____Insurance Phone # _____

Insurance Address_____Claim # _____

Attorney Involved? Y N Attorney Name_____ Attorney Phone # _____

Attorney Address_____City_____ State_____ Zip _____

☐ I acknowledge receipt and review of the CLIENT HANDBOOK. _____Please Initial Here

I authorize the release of information to my insurance company. I authorize my insurance benefits to be paid directly to the Saint Louis Behavioral Medicine Institute. I understand that insurance is filed as a courtesy, and any balance not paid by my insurance company will be my responsibility. SLBMI cannot be held responsible for benefits quoted by insurance company. COPAYS MUST BE MADE AT THE TIME OF SERVICE. I understand all unpaid balances are subject to a finance charge. I agree to reimburse any collection fees incurred in the collection of a past due account.

Signed (Patient or Guardian)_____ Date_____

If signed by a guardian or parent, this is an authorization for medical treatment of a minor.