Behavioral Medicine P.C.

Cynthia Kindgren MS/LCPC
Licensed Clinical Professional Counselor
Owner-Clinical Director

Tara White MSW/LCSW
Licensed Clinical Social Worker
Independent Contract Therapist

Registration Form

Date:_____

Client:_____Birth Date:_____SS#_____

Street:_____City/St:_____ZIP:_____Sex: Male___Female_____

Home#_____Cell#_____WK#_____Marital Status: M S W D

E-mail:_____

Referral Doctor: First Name_____ Last Name_____Phone_____

Responsible Party

_____Self _____Spouse Name of Spouse:_____ Birth Date_____

Relation:_____ Name:_____ Birth Date_____

Responsible Party's Social Sec No:_____

Primary Insurance

(Please provide a copy of Primary Insurance Card if applicable)

____Medicare ____Commercial _____Work Comp(See Below) ___Self Pay _____Auto(See Below)

Insurance Co:_____Phone#_____

Group#_____ Member ID:_____

Street:_____ City/St:_____

Secondary Insurance

(Please provide a copy of Secondary Insurance Card if applicable)

____Medicare ____Commercial ____Work Comp(See Below) ____Self Pay ____Auto(See Below)

Insurance Co:_____Phone:_____
Group#_____Member ID:_____
Street:_____City/St:_____

Auto Accident/Work Comp

Date of Accident:_____ State of Accident:_____
Type of Accident: _____Auto _____Work Related Claim#_____
Case Manager: Name:_____ Phone#_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Behavioral Medicine, PC (BMPC) to release to insurance companies, governmental agencies, or their intermediaries, third party payors and physicians participating in my care, or their agents, any medical records or other information necessary to obtain payment for medical services provided to me, including medical, psychaiatric, psychological, school, vocational records of evaluation and/or treatment for physical and/or emotional illness including past history, diagnosis, complications and residuals, prognosis, progress notes, medication, workshop evaluations, training reports, IQ scores, treatment plans, recommendations, summaries, current status, evaluation and treatment records of alcohol or drug abuse, records of HTLV-3 or HIB testing(AIDS Tests) results, and AIDS treatment records. I request that BMPC submit all medical charges to insurance companies, governmental agencies or their intermediaries, third party payors, providing benefits to me.

ASSIGNMENT OF BENEFITS

In consideration of the medical services provided or to be provided by BMPC, any and all rights which I have against insurance companies, governmental agencies or their intermediaries, or third pary payors, for payment of charges for services provided or to be provided by BMPC, to me or to one of my dependents I understand that I am responsible for and will pay the portion(or full amount) of my bill not covered by insurance companies, governmental agencies or their intermediaries, or third party payors. I further understand that any overpayment will be reviewed and refunded to the appropriate payor.

Signature (Client or Guardian of minor child)_____