BEHAVIORAL CONSULTATION L.L.C.
1520 U.S. Highway 130, SUITE: 203, NORTH BRUNSWICK, NJ 08902
(732) 658-3870

Today's Date: _____

Patient's Name: _____ _____ _____
Last First Middle
Date of Birth: _____ Gender: _____ Marital Status: _____

Email: _____ Race: _____ Ethnicity: _____

Address: _____ Apartment: _____

City/Town: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

School: _____ Grade: _____

Primary Care Physician: _____

Address: _____ Suite #_____

City/Town: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name of Insurance: _____ Member ID: _____

Group No: _____ Name of Subscriber: _____

Subscriber's Date of Birth: _____ Subscriber's Gender: _____

Subscriber's Address: _____ Apartment: _____

City/Town: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Patient relationship to subscriber: _____

Emergency Contact Name: _____

Relationship to the patient: _____ Phone: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. INITIALS: _____

Patient/Guardian Signature: _____ Date: _____

Reason for Visit: _____

_____

Medical Condition: _____

_____

_____

_____

Surgery: _____

_____

_____

_____

Current Medications: (List all the medications you are currently taking including vitamins and herbal medications): _____

_____

_____

_____

_____

Allergy: _____

_____

Addiction History (Include alcohol, illegal drugs, prescription pills abuse and cigarette): _____

_____

_____

_____

Family Mental Health History: (Include family history of depression, anxiety, bipolar disorder, schizophrenia, suicide, suicide attempt, substance abuse, ADHD or autism): _____

_____

_____

_____

_____

Family Medical History: (Include family history of heart attack, high blood pressure, heart problem, sudden unexplained death at young age, diabetes, cancer, thyroid problem or any other significant family medical history): _____

_____

_____

_____

_____

Pharmacy Name: _____ Phone: _____

Pharmacy Address (If known): _____

Patient/Guardian Signature: _____ Date: _____

Appointment Compliance

All clients on controlled substance must be seen every month.
All clients under 18 year old must be seen every month.

I patient/guardian have read and understood and agree to above policy. Initials: _____

Patient/Guardian Signature: _____ Date: _____

No Show/Cancellation Policy

All missed appointment(s) without 24 hours prior notice/call will result in a bill of $50.00 (Fifty dollars) per visit to you, the patient/guardian. This fee is "non-payable and non-reimbursable" by your insurance company.

I patient/guardian have read and understood and agree to above policy. Initials: _____

Patient/Guardian Signature: _____ Date: _____

Additional Paperwork

There will a charge for any paperwork.
Letters, school notes, work notes, other notes: $10.00
Forms: disability forms, FMLA, other forms: $15.00
Evaluation Reports: $50.00

Patient/Guardian Signature: _____ Date: _____

Please initial following statements and sign the bottom of the page

I authorize that my insurance benefits are paid directly to Behavioral Consultation L.L.C. _____

I authorize the release of any medical information required to process my claim(s). _____

I understand that I am financially responsible for any and all balances on my account. _____

If my insurance doesn't pay for any reasons, I understand I am responsible for bill. _____

If I fail to make a payment after a reasonable amount of time, my account will be turned over to collection agency. _____

Patient/Guardian Signature: _____ Date: _____

Termination

In order to provide best care, keeping regular appointment is necessary. If you miss 2 consecutive appointments or do not show up within 3 months of your last appointment, you will be terminated from our clinic. Initials: _____

_____
Signature of Patient/Guardian

Acknowledgement of Privacy Notice

I, _____, have received a copy of Behavioral Consultation L.L.C. Notice of Privacy Practices, Grievance Procedure and Patient's Rights.

_____
Print Patient's Name

_____ _____
Print Parent/Guardian's Name (for minor) Relationship to Patient

_____ _____
Signature of Patient/Guardian Date

Communication Preference

If you would like to receive Text Messages, voice mails and/or Emails for appointment reminders we need your consent.

Patients in our practice may be contacted via text messages, voice mails and/or Email for appointment reminder. If you would like a reminder please provide phone number and /or Email to give us consent:

Text Message/Voice Mail at: _____ Email at: _____

I consent to receive text message/voice mail/Email reminder messages for Behavioral Consultation LLC at my Cell Phone (and any number forwarded or transferred to that number) and/or at Email Address to receive appointment reminders. I understand that messages may come from third party and text/voice/Email messages will apply to all future appointment reminders unless I request a change in writing. Standard text/voice messaging rate may apply by your wireless carrier.

_____ _____
Patient/Guardian Signature Date

_____
Patient/Guardian Name