



REGISTRATION FORM

CLIENT INFORMATION

DATE: / /

Client Name (First, MI, Last): _____			
Address (Street, City, State, Zip): _____		Contact Information: Cell Phone: () _____ Work Phone: () _____	
Date of Birth: <u> </u> / <u> </u> / <u> </u>	Gender: Male Female	Social Security # - - -	May we contact you for appointment reminders? Y/N Circle preferred method: Cell# Work# Email
Email: _____			
Occupation: _____		Name of Employer: _____	
Emergency Contact Information: Name: _____ Cell Phone: () _____ Work Phone: () _____ Relationship to Client: _____		Race/ethnicity with which you identify self (optional): <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> East Asian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> African American <input type="checkbox"/> Other: _____	

PARENT OR GUARDIAN

Client is a minor, please complete parent/guardian information. *Address need only be completed if different than Client.

Parent/Guardian Name: _____	Parent/Guardian Name: _____
Date of Birth (Parent/Guardian): _____	Date of Birth (Parent/Guardian): _____
Relationship to Client: _____	Relationship to Client: _____
Address: _____	Address: _____
Name of Employer: _____	Name of Employer: _____
Cell Phone: () _____ Work Phone: () _____ Other Phone: () _____	Cell Phone: () _____ Work Phone: () _____ Other Phone: () _____
Email: _____	Email: _____
May we contact you for appointment reminders? Y/N Circle preferred method: Cell # Home# Email	May we contact you for appointment reminders? Yes/No Circle preferred method: Cell# Home# Email

OTHER HOUSEHOLD OR FAMILY MEMBERS

Name:	Relationship:	Date of Birth:	Age:
		__/__/__	
		__/__/__	
		__/__/__	
		__/__/__	

PHYSICIAN INFORMATION

Physician's Name:	Address:
Phone Number:	Fax Number:

INSURANCE INFORMATION

I do not have insurance benefits to cover the services and I agree to pay for services before they are rendered.

Primary Carrier*	Phone Number	
Address		
Policy Holder		
Policy/Member #	Person Code (If known)	Group #

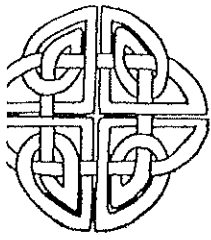
*Please provide copy of the front and back of insurance card

Secondary Carrier*	Phone Number	
Address		
Policy Holder		
Policy/Member #	Person Code (If known)	Group #

*Please provide copy of the front and back of insurance card

My signature indicates that the above information is accurate and true to the best of my knowledge. I understand that this registration form must be updated yearly.

Client Name:	Date of Birth:
Signature of Client (Adult or Minor age 14 years of older):	Print Name: Date: __/__/__
Signature of Parent/Guardian if signer is under the age of 18 years:	Print Name: Date: __/__/__
Signature of Witness:	Print Name: Date: __/__/__



SPECTRUM

BEHAVIORAL HEALTH LLC

**CONFIRMATION OF UNDERSTANDING FOR POLICY, PROCEDURE, HIPPA, CLIENT RIGHTS
AND OTHER PERTINANT INFORMATION FOR SPECTRUM BEHAVIORAL HEALTH LLC
CLIENTS**

Client Name: _____ Date of Birth: _____

My signature below indicates that I have read understand and attest to the following:

- The information that I have provided on this registration form is current and true to the best of my knowledge.
- I permit a copy of this authorization to be used in place of the original.
- I understand that this consent may be revoked by me at any time, except to the extent that action has already been taken. This consent remains valid unless expressly revoked.
- I hereby release Spectrum Behavioral Health LLC from and legal responsibility or liability that may arise from the act of filing my insurance claim.
- I have been advised of the cost of treatment (Please see Financial Agreement (page 4) & Important policy and procedure information for Spectrum Behavior Health LLC clients (pages 6-7).
- I understand that it is ultimately my responsibility to ensure that my insurance carrier will cover the cost of services received at Spectrum Behavioral Health LLC and if I do not have other coverage, I will be responsible for the bill.

My signature below indicates that I have been given a copy of "Spectrum Behavioral Health LLC's "Important Policy and Procedure Information for Clients" handout, the "Client Rights and the Grievance Procedure for Community Services", "Informed Consent for Mental Health Evaluation and/or Treatment" and "Financial Agreement" information and the *Spectrum Behavioral Health LLC Notice of Privacy Practices*". For clients age 12-17, I have been given a copy of the "Rights of Children and Adolescents in Outpatient Mental Health Treatment" brochure.

Signature of Client (Adult or Minor age 14 years of older)

Date

Signature of Parent/Guardian if signer is under the age of 18 years

Date

Signature of Clinician

Date

FINANCIAL AGREEMENT

*Guarantor: Refers to the person responsible for receiving and paying the bill for medical services. The guarantor may or may not be the client. A parent or legal guardian/trustee is the guarantor for clients 18 years old and under. This is also the case for clients with a decreased mental capacity.

As a guarantor, you are responsible for the costs of services provided by Spectrum Behavioral Health LLC. We ask that you pay any expected co-pay/personal fees at the time of each visit. If we underestimate your co-pay, you will be billed at the end of each month, and we ask that you make payment within 30 days. Should you over pay, any payment will be promptly refunded. As a service to our clients, insurance claims will be submitted to your insurance carrier(s).

If you have HMO coverage and have a current referral, your policy may cover the initial costs if benefits have not already been used elsewhere. If your HMO requires you to have a referral for services that we provide at our office, it is your responsibility to obtain a referral and keep that referral current. You will personally be responsible for the co-pay portion of the benefits, for costs incurred during any period in which you do not have a current referral, and for services you receive that are not covered by your HMO.

If you have non-HMO insurance, you will be responsible for deductible and co-pay portions. You are responsible for any prior authorizations that may be needed. You are also personally responsible for any costs that exceed the benefit limits of your insurance policy or are not covered by your policy. If you have questions about what your insurance may cover, you should contact your insurance company and check benefits.

If you or your child have a Wisconsin ForwardHealth Medicaid plan you are responsible for keeping your ForwardHealth Medicaid coverage current. If you have a lapse in Wisconsin ForwardHealth Medicaid coverage, or coverage is cancelled, you will be responsible for payment of services. We will always bill your private insurance first for services provided. If your private insurance will not cover services, we will then bill your Wisconsin ForwardHealth Medicaid plan.

Although we are in network with many insurance carriers, this coverage can vary from clinician to clinician. You are responsible to contact your insurance carrier to verify "in network" status.

Fees for professional services:

Diagnostic Interview and Intake Assessment	\$ 150.00
Ongoing Psychotherapy Treatment Services	\$ 30.00 per 15 minute unit (ex. 45 minutes = \$90.00)
No Show Fee (Insurance does not cover)	**See below

**If you fail to attend or fail to cancel a previously scheduled session with at least 24 hours' notice you may be charged a fee which could equal the fee for the services in which you were scheduled to receive. **

Certain situations and/or services are not reimbursed by insurance and must be paid in advance. These billable tasks include: School visits, letter preparation, court visits, copying records, paperwork completed for outside agencies, and telephone consultations over 5 minutes. A fee schedule for these expenses can be obtained from each individual clinician.

Accounts must be kept current and monthly statements must be paid upon receipt unless written arrangements have been made. If your account balance goes above \$500, and you have not made payment arrangements with our office, we may ask that you temporarily stop services until your account is brought up to date. For your convenience, our office does accept MasterCard and Visa. If you have any questions regarding your account, please ask our account manager. Spectrum Behavioral Health, LLC reserves the right to seek legal means to secure reimbursement.

My signature below indicates that I have read, understand, and agree to the policies described above and that I understand that I am responsible for my bill with Spectrum Behavioral Health LLC regardless if I have insurance coverage or not.

Client Name:		Date of Birth: / /
Signature of Guarantor:	Print Name:	Date: / /
Witness:	Print Name:	Date: / /