New Client Registration

Today's Date: _____

Name: _____ Age: _____ Gender: _____

Address: _____City/State: _____ Zip: _____

Date of Birth: _____ Relationship Status: _____

Social Security #: _____Home Phone: _____Cell Phone: _____

E-mail: _____

May we call you at either number? Y N Leave a message at either number? Y N

Person responsible for bill: ( ) Same as Patient
Name: _____ Relationship _____Phone: _____

Address: _____City/State: _____ Zip: _____

Employer Information:

Employer: _____

Address: _____ City/State: _____Zip: _____

Work Phone: _____May we call you at this number? Y N Leave a message at this number? Y N

In Case of Emergency, Notify:

Name: _____Relationship _____

Phone Number: _____

Household Information

Name	Date of Birth	Relationship	Occupation/Grade in School

Insurance Information

Primary and Secondary Insurance with Subscriber Info (attach copy of both sides of insurance cards, claims address required) Is Insurance being used? Y N

Primary Insurance Company Name: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient _____Primary Phone:_____

Member ID/Policy: _____ Group Number _____ Effective Date: _____

Secondary Insurance Company Name: _____

Subscriber Name: _____Subscriber Date of Birth: _____

Relationship to Patient: _____ Primary Phone: _____

Member ID/Policy: _____ Group. Number: _____Effective Date: _____

Authorization for Release of Information

I authorize Inspire Therapeutic Services, LLC to release to my insurance carrier or its designated agents any information concerning mental health care, advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Inspire Therapeutic Services in writing of any information I do not want released.

_____ _____

Signature Date

Assignment of Benefits

I authorize the assignment of benefits payable to Inspire Therapeutic Services, LLC and/ or its designee for behavioral health services and supplies or any other private third payer. I understand that I'm responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

_____ _____

Signature Date

Health

Primary Physician: _____ Phone:_____

Address:_____

Date of last physical exam: _____ Please list any health problems: _____

Authorization to Disclose Protected Health Information (PHI) to Primary Care Physician (PCP)

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care.
This information will not be released without your signed authorization. This PHI may include diagnosis and treatment plan.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

_____I agree to release any applicable mental health/substance abuse information to my PCP

_____I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health

services, and I direct you **NOT** to so notify him/her.

_____ _____

Patient Signature Date

Your rights:

- You can end this authorization (permission to use or disclose information) any time contacting our office
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You do not have to agree to this request to use of disclose information