RESPONSIBLE PARTY INFORMATION

Responsible Party: Self Guarantor (If guarantor is Not the patient provide responsible party)

Responsible Party Name (Last) _____First) _____ (MI) _____

Guarantor SSN: _____-_____-_____ Guarantor Date of Birth: _____/____ /_____
mmddyy

Address: _____ City _____ State _____ Zip _____
_____

Home Phone (_____) _____ Cell Phone (_____) _____

PRIMARY INSURANCE INFORMATION (Provide your insurance card at the front desk)
Insurance Company: _____

Phone Number: (_____) _____

Name of Insured: _____ Patient Relationship to Insured: _____

Subscriber ID (Policy Number): _____ Group ID: _____

SECONDARY INSURANCE INFORMATION
Insurance Company: _____ Phone Number: (_____) _____

Name of Insured: _____ Patient Relationship to Insured: _____

Subscriber ID (Policy Number): _____ Group ID: _____

CONSENT TO TREATMENT

___ I am a patient of **JCW** **Mental Health LLC.** By signing this form, I give my consent to be treated by the doctors of this practice.
___ I understand treatment and services may include:

- Lab tests
- Routine exams
- Screening tests (tests that can find an illness early, before a person shows signs of having the disease)
- Diagnostic tests (tests that shows if a person has a certain illness or health problem)

___ I understand that no promises have been made to me about the results of any treatment or services.
___ I acknowledge that I have read and understood each of the above provisions appearing on this page.
___ I have also had the opportunity to ask any questions, and by my signature, I consent and agree to such provisions individually and collectively. A copy may be used in lieu of the original.

Patient or Responsible Person Signature _____ **Date** _____/_____/_____
mmddyy