Change Happens, INC

INTAKE PERSONAL AND INSURANCE INFORMATION

PERSONAL INFORMATION

Name **D.O.B.**

Address **Gender Orientation**

City / State / Zip

Marital Status

Preferred Contact Number(s)

Last Four Digits of SSN

RESPONSIBLE PARTY

(Fill in if under 18 or if someone other than client is responsible for payment and / or is the subscriber)

Name **D.O.B.**

Address

City / State / Zip

Preferred Contact Number(s)

Relationship to Patient

FINANCIAL POLICY

Appointments cancelled with less than 24 hours notice will be charged to me in accordance with the cancellation policy schedule unless prohibited due to the insurance payors policy. I have been offered a copy of the policy and I understand and agree to the above and understand and agree to the information set forth in the Outpatient Services Contract.

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Patient/Parent/Guardian/Legal Representative Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not ha health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand as set forth in the Outpatient Services Contract that my health insurance benefits are designed to help with part or all reimbursement and that it is my responsibility to verify and / or obtain authorization if required, meet any / all deductibles or co-pays, and to pay for services not covered by my health insurance. I authorize payment of medical benefits to my provider for services performed.

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Patient/Parent/Guardian/Legal Representative Signature Date