

Shorehaven **BEHAVIORAL HEALTH, INC**

REGISTRATION FORM AND PAYMENT PLAN

Please PRINT. Please fill in this important information as completely as possible. If the client is a *child or adolescent*, put the child's information in the first box. If this is *couples therapy*, in the first box place the name of the person in whose name we are to bill.

Client's Name _____		Sex: M F	Date of Birth: ___/___/___
Address: _____		City: _____	
State/Country: _____	Zip/Postal Code: _____	CLIENT Soc Sec Number (for billing purposes): _____	
Hm Phone:(____)	Cell Phone: (____)	Email _____	
If working, Employer: _____	Business Phone: _____	Occupation: _____	
Employer Address: _____	City: _____	State: _____	Zip: _____

If the client is a *child or adolescent*, in the next box put the information for the guardian/parent. If one parent has the insurance, put in the box the information for the parent whose insurance covers this child. If this is *couples therapy*, put the information for the partner in the next box.

<u>CHECK RELATIONSHIP TO THE CLIENT</u> Spouse/Partner _____ Parent _____ Guardian _____ Foster Parent _____			
Name _____		Sex: M F	Date of Birth: ___/___/___
Address: _____		City: _____	
State/Country: _____	Zip/Postal Code: _____	Soc. Sec. No.: _____	
Hm Phone:(____)	Cell Phone: (____)	Email _____	
If working, Employer: _____	Business Phone: _____	Occupation: _____	
Employer Address: _____	City: _____	State: _____	Zip: _____

If the client is a *child or adolescent*, put the information on the other parent in the next box.

<u>CHECK RELATIONSHIP TO THE CLIENT</u> Parent _____ Guardian _____ Foster Parent _____			
Client's Name _____		Sex: M F	Date of Birth: ___/___/___
Address: _____		City: _____	
State/Country: _____	Zip/Postal Code: _____	Soc. Sec. No.: _____	
Hm Phone:(____)	Cell Phone: (____)	Email _____	
If working, Employer: _____	Business Phone: _____	Occupation: _____	
Employer Address: _____	City: _____	State: _____	Zip: _____

Emergency Information: Name of Closest Relative: _____		
Relationship: _____	Phone:(____)	Address: _____
City: _____	State: _____	Zip: _____

Insurance and payment plan information is on the reverse side.

Insurance and Payment Plan Information

Primary Insurance Plan: We need complete information in order to bill your insurance

Primary Insurance Company: MEDICAID/Badgercare – if Medicaid, which one: Straight Medicaid (Badgercare Standard) I Care
 United Health Care (UBH, Optum Health) Managed Health CCHP ABRI Family Care Wraparound
 Medicare - If Medicare, which one: Evercare Other Medicare HMO
 Blue Cross Aetna Humana Health EOS WEA Other Insurance Company: _____
Subscriber: _____ Subscriber Birth date _____
If subscriber is not the client, then we need subscriber's SSN _____
Address, if different from client _____
Group # _____ Subscriber # or billing ID# _____
Insurance Company Phone # _____
Claims Address _____

Second Insurance Plan : We need complete information in order to bill your insurance.

Primary Insurance Company: MEDICAID/Badgercare – if Medicaid, which one: Straight Medicaid (Badgercare Standard) I Care
 United Health Care (UBH, Optum Health) Managed Health CCHP ABRI Family Care Wraparound
 Medicare - If Medicare, which one: Evercare Other Medicare HMO
 Blue Cross Aetna Humana Health EOS WEA Other Insurance Company: _____
Subscriber: _____ Subscriber Birth date _____
If subscriber is not the client, then we need subscriber's SSN _____
Address, if different from client _____
Group # _____ Subscriber # or billing ID# _____
Insurance Company Phone # _____
Claims Address _____

Payment Plan: 1. I will pay the usual and customary fee (or a negotiated rate) at each session by cash or check OR by credit card:
(circle) Visa MC Card No. _____ Expiration: ____/____ Security Code: _____.

A receipt will be given or sent to me.

- 2. I will submit the bill to my insurance co. and collect from my insurance. I will pay the usual and customary fee at each session.
- 3. SBH will bill my insurance. I will pay any amounts which the insurance does not, such as deductibles and co-payments, or for which my insurance is not responsible. If insurance benefits are exhausted, I will pay the usual fee. I will pay any co-payments at each visit.
- 4. Other agreement negotiated with therapist: _____
- 5. Medicaid SED In-Home Program or other program which has no co-payments

Payment Plan Agreement. I make this agreement with the knowledge and understanding that I accept full responsibility and liability for any and all charges incurred and guarantee timely payment of the agreed upon charges. I also understand that I will be liable for any costs associated with collection activities due to delinquent charges, including costs levied by collection agencies, legal fees, search fees, or other related collection costs. Bank charges for bounced checks will be charged at the customary rate charged by SBH's bank. SBH may charge interest (1%/month) on unpaid balances commencing one month following a notification letter being sent to me.

Medicaid and Medicare. If I am covered by Medicaid or Medicare, I am authorizing SBH to bill any Medicaid or Medicare HMO in which I may from time to time be enrolled.

Cancellations. If for any reason an appointment cannot be kept, therapist must be notified one day in advance or the customary charge will be made. Missed appointments cannot be billed to insurance.

Authorization to Bill. My signature below authorizes Shorehaven Behavioral Health, Inc., (SBH) (1) to file insurance claims with my insurers, whichever may be insuring me at the time of service, for services provided to patient without obtaining my signature on each and every claim to be submitted and (2) to release any information needed to process my insurance claims or to collect on my bill and (3) to bill the charge card listed above. Assignment of Benefits. I authorize my insurance carriers to pay, and I assign, directly to SBH all benefits from my insurance for services provided by SBH.

Signature: _____ Date: ____/____/_____
(Parent or patient if over 13)

Signature: _____ Date: ____/____/_____
(Second patient or parent, if responsible for payment)

Therapist: 1) Please make sure information is complete. 2) A new Client Insurance Change Notice form is required when the client's primary or secondary insurer changes.