SHOREHAVEN
BEHAVIORAL HEALTH, INC.

# Registration and Payment Plan

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

## Client Information

**Client's Name:** _____ **Sex:** ☐ M ☐ F **Date of Birth:** _____

**Street Address:** _____ **City:** _____

**State:** _____ **Zip Code:** _____ **Client SSN** (for billing purposes): _____

**Phone:** _____ ☐ **I have texting on this number.**

**Email:** _____

**Employer:** _____ **Business Phone:** _____ **Occupation:** _____

Are you on disability or have you applied for Social Security disability benefits? ☐ Yes ☐ No

## Minor Child & Additional Client Information

(Spouse/partner information for couples' therapy; parent/legal guardian information)

**Relationship to Client:** ☐ Spouse/Partner ☐ Parent ☐ Guardian ☐ Foster Parent

**Name:** _____ **Sex:** ☐ M ☐ F **Date of Birth:** _____

**Street Address:** _____ **City:** _____

**State:** _____ **Zip Code:** _____

**Phone:** _____ ☐ **I have texting on this number.**

**Email:** _____

**Employer:** _____ **Business Phone:** _____ **Occupation:** _____

## Emergency Contact Information

**Name:** _____

**Relationship:** _____ **Phone:** _____

## Primary Insurance Information

(We need complete information in order to bill your insurance.)

**Primary Insurance Company:** _____ **Insurance Phone:** _____

**Subscriber** (if other than client)**:** _____ **Subscriber Date of Birth:** _____

**Street Address** (if other than client)**:** _____ **City:** _____

**State:** _____ **Zip Code:** _____ **Subscriber SSN** (if subscriber is not client): XXX – XX – _____

**Group Number:** _____ **Subscriber Number or Billing ID:** _____

**Claims Address:** _____

## Secondary Insurance Information

(If you have secondary information, please list it here.)

**Secondary Insurance Company:** _____

**Group Number:** _____ **Subscriber Number or Billing ID:** _____

## Payment Plan Information

☐ 1. Shorehaven 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.

☐ 2. I will pay the usual and customary fee by cash, check, or credit card:

☐ **Visa** ☐ **Mastercard**

**Card Number:** _____ **Expiration:** _____ **CVV:** _____

☐ 3. Other fee agreement negotiated with therapist using discounted fee scale: _____

☐ 4. I will submit the bill to my insurance company and collect from my insurance. I will pay the usual and customary fee (or negotiated rate) at each session.

**Payment Plan Agreement.** I made this agreement with the 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 necessitated by delinquent outstanding charges, including costs levied by collection agencies, legal fees, search fees, or other related collection costs. The charge for returned checks is $25.00. Shorehaven may charge interest (1.5%/month) on unpaid balances delinquent commencing one month following a statement being sent to me.

**Payment for Missed Appointments.** If, for any reason, an appointment cannot be kept, the therapist must be notified 24 to 48 hours in advance and, when applicable, you may be responsible for payment of the customary charge for the missed appointment.

**Authorization to Bill.** My signature authorizes Shorehaven Behavioral Health, Inc. 1) to file insurance claims with my insurer 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 credit card of file.

**Assignment of Benefits.** I authorize my insurance carrier to pay, and I assign directly to Shorehaven, all benefits from my insurance for services provided by Shorehaven.

**Client if 14 or older:**

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |

**If client is less than 18, person authorized to sign for client:**

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |