CENTRAL BEHAVIORAL HEALTHCARE, INC.
PLEASE PRINT CLEARLY ON THIS REGISTRATION FORM

PATIENT INFORMATION

____
Last Name **First** **Middle**

____
Address- Street **City** **State** **Zip Code**

(____) _____-_______ (____) _____-________ (____)-____-______
Home Phone # **Work Phone #** **Cell Phone #**

____/____/____ ______ ______ ______- ______- ______
Date of Birth **Gender** **Marital Status** **Social Security Number**

PERSON LEGALLY RESPONSIBLE FOR PAYMENT

Patient _____ Parent _____ Other (and specify relationship) ________________

____
Last Name **First** **Middle**

____
Address **Street** **City** **State** **Zip Code**

(___)-_____-_____ (____)-_____-_____ ______________________________
Home Phone **Cell Phone** **Relationship to minor child**

If not the patient, is this person expecting to receive a bill for services rendered? ___

____
Employer Name/Company Name

____
Address **Street** **City** **State** **Zip Code**

(____)-_____-_____ ____
Phone **Employee Name**

METHOD OF PAYMENT

____ Self Pay
____ Health Insurance
____ Other (specify):____

PRIMARY INSURANCE INFORMATION

____
Insurance Company **Phone Number**

____
Address No. and Street **City** **State** **Zip**

____
Identification Number **Group Number** **Employer Name**

____
Insured Employee Name

____
Address **Street** **City** **State** **Zip**

____/____/____ ______-______-________ _______
Date of Birth **Social Security Number** **Gender**

(_____)______-______ (______)______-______
Home Phone Employee **Cell Phone Employee**

Relationship of insured to patient: **Self ___ Parent ___ Spouse ___ Other ____**

SECONDARY INSURANCE INFORMATION

____
Insurance Company **Phone Number**

____
Address No. and Street **City** **State** **Zip**

____
Identification Number **Group Number** **Employer Name**

____
Insured Employee Name

____
Address **Street** **City** **State** **Zip**

____/____/____ ______-______-________ _______
Date of Birth **Social Security Number** **Gender**

(_____)______-______ (______)______-______
Home Phone Employee **Cell Phone Employee**

Relationship of insured to patient: **Self ___ Parent ___ Spouse ___ Other _____**

I understand that payments for these services are my own responsibility and of the person so designated as legally responsible on page one. If self- paying, my signature below confirms knowing it is my responsibility to fulfill this obligation.

By supplying the information about my insurance coverage below, I am indicating I want to use insurance coverage and hereby authorize Central Behavioral Healthcare, Inc. to furnish complete information regarding services rendered and to bill my insurance company(ies) for all services. I authorize payment of benefits directly to Central Behavioral Healthcare, Inc. I understand that billing my insurance company(ies) does not change my responsibility for knowing my insurance benefits, limits, number of visits, and co-payments and being sure Central Behavioral Healthcare, Inc. is fully paid for rendered services. I will self-pay charges that are not covered by my insurance, including my co-payments.

Primary Insurance Company____

Secondary Insurance Company____

____ ________________
Patient's Signature Date