CROSSROADS BEHAVIORAL HEALTH

I welcome you to my practice. While you are waiting to meet with me, I would appreciate your completing these forms. The information you are providing will be very important in my getting to know you, as well as in assisting you with the processing of your insurance claims. I look forward to meeting you.

Intake Date _____HICF_____ Pt Statement _____ to IP____ Parent____
DX Code: (1)_____ (2)_____ (3)_____

Patient Information

Patient Name _____ Date of Birth _____
Address _____ Social Security #_____
_____ Relationship to Insured **(Circle One)**
_____ *Self Spouse Child Other*
City State Zip Sex: F____ M_____
Phone (h) (____)_____ Marital Status: S____ M____ D____ Sep_____
Phone (w) (____)_____ Student Status: N/A____ Full_____ Part_____
Phone (c) (____)_____ Referred By: _____
Email address (optional) _____
Primary Care Physician _____ PCP Phone (___)_____

In Case of Emergency Contact

Name_____ Phone (___)_____

Insured/Guarantor Information ***(Please fill-in if you need a statement to submit to your health insurance co)***

Insured's Name _____ Date of Birth _____
Address _____ Social Security # _____
_____ Sex: F____ M____
_____ Employment Status **(Circle One)**
City State Zip *Full time Part time Unemployed Retired*

Phone (h) (____)_____ Phone (w) (____)_____
Employer _____ Occupation _____
Insurance Company Name _____ **Insurance ID #**_____
Plan Name _____ Group # _____
Insurance Phone (____)_____

Beneficiary/Guarantor Signature ***(Initial and Sign)***

_____ I understand I will be charged for the full amount of my scheduled visit for cancellation (less than 24 hours) or "failure to show" for an appointment, and I understand that **cancellation must be made by telephone only.** This is not covered by insurance.

_____ I have received a copy of the Connecticut Notice of Privacy Practices for Crossroads Behavioral Health. (Copies are available on the clipboard and in the waiting room)

_____ _____
(Signature of Beneficiary/Guarantor) *(Date)*