CLIENT INFORMATION

Section I **Date**

Name I prefer to be called

Date of birth *(mm/dd/yyyy)* Social Security Number

Address City State Zip

Email

Home Phone Work Phone Cell Phone

The best time to contact me ☐ AM ☐ PM on my ☐Home phone ☐ Work Phone ☐ Cell phone

I consent the use of *(check applicable)* ☐ phone ☐ email ☐ postal mail ☐ other for communication *(Client/Guardian initial here)*

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If student, Name of School City/State ☐ FT ☐ PT

Spouse or Parent's Name Employer Work Phone

Whom may we thank for referring you?

Section II **Guardian(s)**

Relationship to Client ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name

Address

City State Zip Phone

Date of birth *(mm/dd/yyyy)* Social Security Number

Employer

City/State Work Phone

Section III **Emergency Contact**

Relationship to Client ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name

Address

City State Zip Phone

Employer

City/State Work Phone

Section IV Financially Responsible Party

Relationship to Client ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name

Address

City State Zip Phone

Date of birth *(mm/dd/yyyy)* Social Security Number

Employer

City/State Work Phone

Section V Insurance Information

Name of Insured Relationship to client ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured Date of birth *(mm/dd/yyyy)* Insured Social Security Number

Employer Work Phone

Address City/State Zip

Insurance Company

Member ID# Group#

Insurance Company Address/City/State/Zip

Insurance Company Phone

Mental Health/Behavioral Health Eligibility/Benefits Phone number

Mental Health/Behavioral Health Eligibility/Benefits Additional Info

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ NO ☐ YES If YES, complete the following

Name of Insured Relationship to client ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured Date of birth *(mm/dd/yyyy)* Insured Social Security Number

Employer Work Phone

Address City/State Zip

Insurance Company

Member ID# Group#

Insurance Company Address/City/State/Zip

Insurance Company Phone

I authorize the release of any and all necessary information required by the insurance company. I also authorize Wellspring Behavioral Health to receive payment for services directly from the insurance company. Further, I understand that I am responsible for all charges incurred and that denial of insurance payment does not release from this obligation.

Signature of applicant Date

Signature of guardian Date

Section VI Authorization for Release/Exchange of Information

This section provides Wellspring Behavioral Health with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current healthcare providers, parent, spouse, family member)

I, *(printed name of Client or Authorized Representative)*

authorize Wellspring Behavioral Health. to release and/or exchange information about this case with the following parties:

Name **Relationship to client**

Address

City/State Zip Phone Fax

Name **Relationship to client**

Address

City/State Zip Phone Fax

Name **Relationship to client**

Address

City/State Zip Phone Fax

Information to be Released or Exchanged (check all that apply)

☐ Intake and History	☐ Diagnosis and Treatment Plan	☐ Treatment Progress	☐ Discharge Summary
☐ Verbal Consultation	☐ Billing and Payment	☐ Psychological Testing Results	☐ Behavior programs
☐ Summary Reports	☐ Appointment Information	☐ Diagnostic Assessment	
☐ Other			

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one (1) year this consent automatically expires. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Client Signature (if over 18 years or emancipated) Date

Authorized Representative Signature Date