Integrated Behavioral Health

Madison ▫ Muscle Shoals ▪ Decatur ▪ Cullman ▪ Birmingham 1-855-422-1618

Patient Information			
First Name:	Last Name:	MI	DOB

Marital status (circle one) Single / Married / Divorced / Sep / Widow	AGE	SSN	SEX ☐ M ☐ F

Mailing Address:	City State Zip

May we use this address to mail you necessary information please circle yes no

Cell Phone: May we leave a message/text circle Yes No	Alternate number: May we leave a message/text circle Yes No

Email Address: Email: Yes No

EMERGENCY INFORMATION

Emergency Contact: Name:	Emergency Contact Relation: Phone:

BILLING INFORMATION

Primary Insurance/Guarantor Information		**Secondary Insurance/Guarantor Information**	
Primary Insurance Plan:		Secondary Plan:	
Subscriber Name:	DOB	Subscriber Name:	DOB
Contract #	Group#	Contract #	Group#
Relationship to subscriber ☐ self ☐ spouse ☐ child ☐ Other : _____		Relationship to subscriber ☐ self ☐ spouse ☐ child ☐ Other : _____	

Please Initial_____ I authorize my insurance benefits be paid directly to the physician. I authorize the release of necessary information to third party payers/insurance companies and pharmacies in order to process my claims or fill prescriptions. I understand that I am financially responsible for any balance. If my insurance denies services I understand that I will be responsible for any balance. I understand that as the patient it is my responsibility to verify my benefits.

Please Initial _____I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, visit limit, prior authorization requirements, referral requirements, or any other type of benefit limitation for the services I receive.

_____ Date _____

Signature of Patient or Person granting Authorization on behalf of patient

_____

Printed Name of Person Signing (if not the Patient) Relationship to Patient

Revised 8 2019