New Patient Information

Please fill out the following information to the best of your ability. Do not leave any sections blank. If you have any questions, please ask for assistance.

Identifying Information:

Patient Full Name: ________________________M/F Date of Birth: __________

Mailing Address:________________ City: __________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Employer Name: ________________ Employer Address: ________________

Social Security Number: ______________

Spouse Name: ________________________M/F Date of Birth: __________

Spouse Employer: ______________ Spouse Social Security Number: ____________

Email Address: ____

Parent or Guardian: (Skip to next section if patient is not a minor)

Mother's full name: ______________________ Date of Birth: ______________

Address:________________ City: __________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Employer Name: ________________ Employer Address: ________________

Social Security Number: ______________

Father's full name: ______________________ Date of Birth: ______________

Address:________________ City: __________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Employer Name: ________________ Employer Address: ________________

Social Security Number: ______________

Other Information:

Emergency Contact Person: ______________________ Home Phone: ____________

Relationship to patient: ____

How did you hear about us?:______________________________________

Reason for Referral: ____

Insurance Information: Please provide a copy of your insurance card(s) in addition.

Primary Insurance: ____________

ID# ______________

Group # ______________

Name of Subscriber: ____________

Address of Subscriber: ____________

Subscriber DOB: ____________

Subscriber SS# ____________

Secondary Insurance: ____________

ID# ______________

Group # ______________

Name of Subscriber: ____________

Address of Subscriber: ____________

Subscriber DOB: ____________

Subscriber SS # ____________

PATIENT NAME: ____ **DATE OF BIRTH:** _____________

Primary Care Physician

Physician's Name: ____________________________ Phone: ______________________________

Physician's Address: ____

I DO/DO NOT (Circle one) authorize the mutual exchange of information between Behavioral Medicine Associates, Inc. and my/my child's primary care provider. This authorization does not expire unless noted as follows: _______________. Signature: _________________________

School If not applicable, skip to next section.

School Name: ______________________ Grade: _______________ Teacher: __________________

Address: __________________________________ Phone: ______________________________

I DO/DO NOT (Circle one) authorize the mutual exchange of information between Behavioral Medicine Associates, Inc. and my child's school. This authorization does not expire unless noted as follows: __________________________. Signature: _______________________

Other: (i.e. Referral Source, lawyer, other physician, etc.)

I DO/DO NOT (Circle one) authorize the mutual exchange of information between Behavioral Medicine Associates, Inc. and ___________________. This authorization does not expire unless noted as follows: ______________________. Signature: ______________________

I hereby assign, transfer, and set over to Behavioral Medicine Associates, Inc. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of patient/parent (if under 18): ____________________________________ Date: _______

The patient/parent/responsible party is responsible for all fees. Unless you are a beneficiary of an insurance plan with which we are billing, fees are payable at the time of the visit. If, for any reason, your insurance company fails to pay any portion of the amounts we bill as a courtesy to you, you are responsible for the balance and will be billed accordingly. **Any co-pays and deductibles are due at the time of the visit..** You agree to pay your bill within 10 days of receipt. Attempts will be made to collect payment and/or make payment arrangements. If payment is not received within 30 days, your credit card on file will be charged the amount owed. If a balance still remains, it will be turned over to a collection agency and/or small claims court. We have the option to pursue all lawful collections procedures available and the patient/parent will be responsible for all reasonable costs of collection, including attorney's fees incurred, if any. Unwillingness to pay may result in termination of services.

Signature of patient/parent (if under 18): ____________________________________ Date: _______

PATIENT NAME: ____ **DATE OF BIRTH:** ______________

__________*Initial* Appointments made and not kept are agreed to be considered a late cancellation and will be billed to you and not your insurance company. Cancellation notice must be given 48 hours before your appointment and made by calling (575)623-9322. There will be a charge of $25.00 for all late cancellations and no shows. Excessive late cancellations or missed appointments (2 for testing, 3 for counseling and medication management) may result in your case being closed for one year.

__________*Initial* Requests for records are received from various sources. Records are copied at $10.00 plus 0.20 a page billed directly to you. Turnaround time is approximately 2 weeks from date of payment.

__________*Initial* Letters are often requested by patients or their representatives. There is a $25.00 letter writing fee for all letters written.

A credit or debit card is required as part of the contract for evaluation and treatment regardless of insurance type. This credit card will be charged for **missed appointments** and/or outstanding balances that are past due 30 days.

□ MasterCard Credit Card Number ____-____-____-____
□ VISA
Expiration date ________ CV# from back __________ Zip code ____________
□ DISCOVER
□ AMERICAN EXPRESS Signature ____________________________

I received a copy of *The Notice of Privacy for Patients.* Initial _________

I received a copy of the *Patient Grievance Policy.* Initial ________

I DO/DO NOT (Circle one) authorize Behavioral Medicine Associates, Incorporated to photograph me/my child for the purpose of identification in the patient chart and/or psychological reports. I understand that I can revoke this authorization at any time with no penalty.
Signature of patient/parent (if under 18): ____