InnerView Behavioral Care
MBHC, INC.

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Patient Information

Name____
First Middle Last
Address____
Street Apt.# City State Zip
Telephone____
Home Work Cell
Date of Birth_________________ SS#_________________ Age_______ Sex _____Female _____Male

__Married __Single __Divorced __Widowed __Separated __Domestic Partnership

Patient Occupation_______________________________ Employer_________________________________

Spouse/Partner Name_______________ Date of Birth___________ Spouse/Partner SS#____________
Spouse/Partner Employer____

Responsible Party___________________ Employer ___________________SS#_____________________
Address______________________ Relationship to Pt_________________ Date of Birth ______________

Pt. Family Doctor_________________________________ Address_________________________________
Phone____

Referred By____________________________________ Phone ____________________________________

Emergency contact other than spouse/partner____________________________ Phone_________________

I request payment of authorized insurance benefits, including Medicare/Medicare supplements, be made on my behalf to MBHC, INC. for any services furnished to me. I authorize the release of any medical information needed to determine payment of insurance claims. A photocopy of this form shall be considered as effective and valid as the original. I agree to MBHC's rescheduling and cancellations policy stating all appointments must be changed or cancelled within 24 hours or I will be responsible any fees incurred. All balances must be paid within 120 days unless other arrangements have been made.

The office staff will attempt to give you a reminder call the day before your appointment. Please let them know if you do not wish to have one.

All co-pays are due at time of service. I understand I am fully liable for any balance not paid by insurance.

Signature____ Date_________________________________

Witness____ Date_________________________________