BARRINGTON BEHAVIORAL HEALTH & WELLNESS

Therapist: _____

Date: _____

Client Registration

Last Name: _____

First Name: _____

Middle Initial: _____

Date of Birth: _____

(Please Circle One)

Gender: Male Female

Relationship: Single Married Other

Employment: Employed Student Other

Street Address: _____

City: _____ State: _____

Zip Code: _____

Email Address: _____

Referred By: _____

Employer: _____

SS#: _____

Home Phone: _____

Work Phone: _____ Ext. _____

Cellular Phone: _____

For clients who are under 18 years of age:

Mother/Guardian: _____ Address: _____ Phone: _____

Father/Guardian: _____ Address: _____ Phone: _____

Communication

Would you like to receive appointment reminders? Please choose an option below:

_____ Email _____ Phone Call _____Text _____None

To receive billing statements via email, complete the blue box to the right.

Confirm Email: _____

Patient Login Name:

Temporary Password:

Reenter Password:

The temporary password must follow these rules:

- 8 to 35 characters in length
- Containing both letters and numbers
- No special characters; letters and numbers only

_____ I authorize Barrington Behavioral Health & Wellness to reach me with confidential information

Emergency

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Insurance Information

Primary Insurance Company

Insurance Company: _____ Member ID: _____

Relationship to insured (policyholder): Circle One Group: _____

Self Spouse Insurance Phone: _____

Child Other

Insured Name: _____ Insured Address: _____

Insured DOB: _____ Insured Phone: _____

Insured Address: _____ Insured Employer: _____

Secondary Insurance if Applicable

Insurance Company: _____ Member ID: _____

Relationship to insured (policyholder): Circle One Group: _____

Self Spouse Insurance Phone: _____

Child Other

Insured Name: _____ Insured Address: _____

Insured DOB: _____ Insured Phone: _____

Insured Address: _____ Insured Employer: _____

- My signature below indicates that I give Barrington Behavioral Health & Wellness permission to release any information obtained during treatments of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.
- I understand that I am responsible for all charges, regardless of insurance coverage. In the event your account is over 120 days past due your account may be turned over to a collection agency.
- I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. A photocopy of this assignment is to be considered as good as the original
- **Please note clients will be asked to accept financial responsibility for payment for any scheduled appointment that is cancelled with less than 24 hour notice.**

Signature: _____ **Date**: _____