

## PATIENT INFORMATION

(Please Print Using Black or Blue Ink)

PATIENT					
<b>Last Name:</b>		<b>First Name:</b>		<b>MI:</b>	
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Phone (Required):</b>		<b>Preferred Phone (Select One):</b> C <input type="checkbox"/> W <input type="checkbox"/> O <input type="checkbox"/>			
<b>Home/Cell:</b>	<b>Work:</b>		<b>Other:</b>		
<b>Email:</b>					
<b>SS#:</b>		<b>DOB:</b>			
<b>Sex:</b>	<b>Gender Identity:</b>		<b>Marital Status:</b> Single <input type="checkbox"/> / Married <input type="checkbox"/> / Other <input type="checkbox"/>		
SELF-IDENTIFICATION (OPTIONAL)					
<u>Race:</u>					
<input type="checkbox"/> American or Alaskan Indian	<input type="checkbox"/> Asian		<input type="checkbox"/> African American or Black		
<input type="checkbox"/> Hawaiian or Pacific Islander	<input type="checkbox"/> White		<input type="checkbox"/> Other		
<u>Ethnicity:</u>					
<input type="checkbox"/> Hispanic or Latino			<input type="checkbox"/> Not Hispanic or Latino		
How did you find out about MindpathHealth:					
PATIENT EMPLOYER INFORMATION:					
		<input type="checkbox"/> <b>Employed</b>	<input type="checkbox"/> <b>Student</b>	<input type="checkbox"/> <b>Other</b>	
<b>Company:</b>		<b>Employer Phone#:</b>			
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF NOT PATIENT)					
<b>Last Name:</b>		<b>First Name:</b>		<b>MI:</b>	
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Phone (Required):</b>		<b>Type (Select One):</b> C <input type="checkbox"/> W <input type="checkbox"/> O <input type="checkbox"/>			
<b>Email:</b>					
<b>SS#:</b>		<b>DOB:</b>	<b>Relationship to Patient:</b>		
<b>Sex:</b>	<b>Gender Identity:</b>		<b>Marital Status:</b> Single <input type="checkbox"/> / Married <input type="checkbox"/> / Other <input type="checkbox"/>		
<b>Company:</b>		<b>Employer Phone#:</b>			
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
PATIENT'S PRIMARY CARE DOCTOR					
<b>Doctor:</b>		<b>Practice Name:</b>			
<b>Address:</b>			<b>Phone:</b>		
EMERGENCY CONTACT					
<b>Name:</b>		<b>Phone:</b>			
I hereby authorize payment directly to the physician of the surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.					
PATIENT OR RESPONSIBLE PARTY SIGNATURE					
<b>SIGN:</b>		<b>DATE:</b>			

## PATIENT INFORMATION

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**PLEASE READ CAREFULLY AND COMPLETE**

I have read the Policy and Procedures and understand and accept the policies described above. I agree to pay my insurance co-payment or deductible / co-insurance, and balance due prior to each session.

**PRIMARY INSURANCE INFORMATION**

**Insurance Company:**

**Ins ID No. of Patient:**

**Suffix #:**

**Group Name or No.:**

**Address:**

**City:**

**State:**

**Zip:**

**Ins Phone:**

**Ins Fax:**

**Policy Dates:**

**From:**

**To:**

**Employer Plan:**  **Y**  **N**

**Policy Holder (Subscriber) Name:**

**Relationship To Patient:**

**Address:**

**City:**

**State:**

**Zip:**

**Policy Holder Phone:**

**Date of Birth:**

**SS#:**

**SECONDARY INSURANCE INFORMATION**

**Insurance Company:**

**Ins ID No. of Patient:**

**Suffix #:**

**Group Name or No.:**

**Address:**

**City:**

**State:**

**Zip:**

**Ins Phone:**

**Ins Fax:**

**Policy Dates**

**From:**

**To:**

**Employer Plan:**  **Y**  **N**

**Policy Holder (Subscriber) Name:**

**Relationship To Patient:**

**Address:**

**City:**

**State:**

**Zip:**

**Policy Holder Phone:**

**Date of Birth:**

**SS#:**

## PATIENT INFORMATION

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### INSURANCE AUTHORIZATION FORM

PLEASE READ CAREFULLY AND COMPLETE

**IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE-ON-FILE FORM.**

#### INSURANCE AUTHORIZATION

<input type="checkbox"/>	I authorize use of this form on all my insurance submissions.
<input type="checkbox"/>	I authorize release of information to all my insurance carriers.
<input type="checkbox"/>	I understand that I am responsible for any co-pay, coinsurance, unmet deductible amounts and/or any fees not covered by insurance at the time of my scheduled appointment.
<input type="checkbox"/>	I authorize Mindpath Health to act as my agent in helping me obtain payment for my insurance carriers.
<input type="checkbox"/>	I authorize payment directly to my provider, and hereby assign my right to reimbursement for services rendered to Mindpath Health.
<input type="checkbox"/>	I permit a copy of this authorization to be used in place of the original.

#### PATIENT OR RESPONSIBLE PARTY SIGNATURE

**PATIENT OR RESPONSIBLE PARTY PRINTED NAME:**

**SIGNATURE:**

**DATE:**

### AUTHORIZATION TO RELEASE INFORMATION:

Valid for 1 year

I, \_\_\_\_\_, hereby authorize Mindpath Health to release the following information:

**BILLING**

**SCHEDULE APPOINTMENTS**

**PERSONAL HEALTH INFORMATION AS WRITTEN IN MY MEDICAL RECORDS**

**To the following person(s):**

<b>Name:</b>	<b>Relationship to Patient:</b>
<b>Name:</b>	<b>Relationship to Patient:</b>
<b>Name:</b>	<b>Relationship to Patient:</b>
<b>Name:</b>	<b>Relationship to Patient:</b>

#### PATIENT OR RESPONSIBLE PARTY SIGNATURE

**PATIENT OR RESPONSIBLE PARTY PRINTED NAME:**

**SIGNATURE:**

**DATE:**

**PATIENT INFORMATION**  
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**FINANCIAL ACCEPTANCE  
FORM**

**PLEASE READ CAREFULLY AND COMPLETE**

**We make payment as easy and convenient as possible. You may pay by cash, check, credit or debit card. For outstanding balances, you may pay on our website: [mindpath.com/current-patients](http://mindpath.com/current-patients).**

You may pay past due balances by setting up an End of the Month Pay Plan that would be processed on the 30<sup>th</sup> day of each month. Please keep in mind, if the 30<sup>th</sup> day falls on a weekend or holiday, the monthly payment will be processed on the next following business day. If you would like to continue with an End of the Month Pay Plan, please provide us with a credit or debit card.

 Credit /  Debit:

Card No.:

Exp Date:

Name (As Printed on Card):

 Credit /  Debit:

Card No.:

Exp Date:

Name (As Printed on Card):

**I authorize Mindpath Health to charge any past due balances on my account to the above credit or debit card number on a monthly basis.**

**PATIENT OR RESPONSIBLE PARTY SIGNATURE**

**PATIENT OR RESPONSIBLE PARTY PRINTED NAME:**

**SIGNATURE:**
**DATE:**

**MINDPATH HEALTH CLINICAL RESEARCH INSTITUTE**

You may be contacted by Mindpath Health, a Mindpath Health provider, or an agent of the practice with information about clinical trials that might be of benefit to you or someone for whom you are authorized to make medical decisions. Whether or not you choose to participate in a particular study as a study subject will be voluntary and subject to the circumstances of each trial.

Would you occasionally like to be notified to undergo the screening process for the opportunity to participate in a clinical trial?

 Yes

 No

May we Email you about – and during – a research study?

 Yes

 No

May we Text you about – and during – a research study?

 Yes

 No

**PATIENT INFORMATION**  
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**ACKNOWLEDGMENT OF RECEIPT OF “NOTICE OF PRIVACY PRACTICES”**

**PLEASE READ CAREFULLY AND COMPLETE**

THIS **ACKNOWLEDGMENT** THAT WE HAVE PROVIDED YOU THE OPPORTUNITY TO REVIEW OUR “NOTICE OF PRIVACY PRACTICES” IS REQUIRED BY FEDERAL LAW. THANK YOU FOR YOUR COOPERATION.

I,	_____ <b>(Patient or Responsible Party Name Printed)</b>	, acknowledge that I have received from Mindpath Health the “Notice of Privacy Practices” and have had adequate opportunity to read and review the document.
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**MEDICAL RECORDS CONSENT**

I,	_____ <b>(Patient or Responsible Party Name Printed)</b>	, understand that if I am referred to another provider outside of Mindpath Health, notes about substance abuse may be shared with the provider to whom I am referred.
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**CONSENT TO TREATMENT**

I,	_____ <b>(Patient or Responsible Party Name Printed)</b>	, agree to receive treatment from Mindpath Health. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.
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**PATIENT OR RESPONSIBLE PARTY SIGNATURE**

**PATIENT OR RESPONSIBLE PARTY PRINTED NAME:**

**SIGNATURE:**

**DATE:**

## PATIENT FEES

**Please Be Aware** that when you make an appointment that time is especially made for you. We really look forward to seeing you at your scheduled appointment. However, our goal is that all patients are seen in a timely manner; therefore, the following will be followed:

### PRIMARY INSURANCE INFORMATION

Cancellation ( <b>with</b> – 24 Hour Notice)	No Charge
Cancellation ( <b>without</b> – 24 Hour Notice)	\$60.00
No Call / No Show	\$60.00

**\*\*\* PATTERNS OF CANCELLATIONS WILL BE DISCUSSED  
WITH YOUR PROVIDER\*\*\***

**PLEASE NOTE: FEES ARE SUBJECT TO CHANGE FOR  
SPECIALITY SERVICES**

### NOTICE

You will not be rescheduled for another appointment beyond these parameters without permission from your provider.

Insurance does not pay for Cancelled or No-Show appointments. The above fees will be an Out of Pocket expense for you as an individual.

If you have any questions or concerns about this, please discuss them with your provider.

### ACKNOWLEDGEMENT PATIENT OR RESPONSIBLE PARTY SIGNATURE

**I HAVE READ AND UNDERSTAND THIS POLICY. I AGREE TO PAY ACCORDING TO THE ABOVE**

**GUIDELINES. PATIENT OR RESPONSIBLE PARTY PRINTED NAME:**

**SIGNATURE:**

**DATE:**