

HERITAGE BEHAVIORAL HEALTH CENTER
2485 E. Southlake Blvd. Ste. 180
Southlake, Texas 76092
817-488-9697

We request that you provide us with the following information which will be used for professional purposes only and will remain confidential.

Client Name: _____ Birth Date: _____ Age: _____
Your Name: _____ Relationship to Client: _____
Address: _____ City: _____ Zip: _____
Is it okay to mail correspondence to this address? Yes _____ No _____
If no, is there another address for mailing? _____

Client's SS#: _____ E-Mail Address: _____
Client's Employer: _____ Client's Occupation: _____
Home Ph:() _____ Work Ph: () _____ Cell() _____
May we leave a brief message at home? _____ At work? _____ Cell? _____
(No detailed messages will be left at work, we will just leave a name & number if you're not immediately available)
Spouse's/Partner's Name: _____ Daytime Phone: _____
Insured's Name: _____ His/Her SS#: _____
Insured's Date of Birth: _____ Daytime Phone: _____
Insured's Employer _____ Occupation _____
Insurance Co. _____ Phone #: _____
Type of Plan: _____ Member ID #: _____ Group #: _____
Is there a Secondary Policy? _____ If so, Name of Insured, Co. Name & SS# of Insured: _____

Reason for coming in: _____

Referred by: _____ Previous Treatment(Y/N) _____
Previous Therapists _____ Dates: _____ to _____
_____ Dates: _____ to _____



PLEASE READ THE FOLLOWING CAREFULLY:

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Heritage Behavioral Health Center will honor contractual agreements made with those managed health care companies and Employee Assistance Programs which stipulate specific reimbursement restrictions.

I realize that I will be charged \$75.00 for appointments not canceled within 24 hours of the appointment time.

Signature _____ Date _____

How to benefit from therapy.....

Therapy is the Greek word for change. The success of our work together depends upon the quality of the efforts on both our parts, and the realization that you are responsible for life style choices/changes that may result from therapy. I hereby consent to treatment by the specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have the right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____ Date _____

I hereby authorize the release of necessary medical information for insurance or EAP reimbursement purposes.

X _____ Date _____

I authorize the payment of medical benefits to the provider of services.

X _____ Date _____