## New Horizons Mental Health Services

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Today’s Date:  |

client INFORMATION

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| Last name:  | First:  | Middle Initial: |  |
| Parent/Guardian (if minor): |  |
| Birth date: | Age: | Gender: | Social Security No.: |

Address: City: State: Zip Code:

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| County of Residence: | Home phone no.: | Cell phone no.: |
| Employer: | Position: | Employment Start Date: |
| Employment Status: (Please select one) □ Full Time (35+ hrs) □ Part Time (21-35 hrs) □ Half Time (20 hrs or less) □ Retired □ Disabled  |
| □ Unemployed □ Unemployed (Seeking Work) □ Homemaker □ Self-Employed □ Inmate □ Sheltered □ Student □ Other  |
| Marital Status: (Please select one) □ Divorced □ Married □ Separated □ Single-Never Married □ Widowed □ Other |
| Race: (Please select one) □ White □ African American/Black □ Asian □ Other |
| Ethnicity: □ Hispanic /Latino □ Non-Hispanic/Latino  | How did you hear about us? |
| Disabilities:  |
| Client needs the assistance of an interpreter?  |
| Client needs assistance with visualization of material format? |
| Behavioral Health Advance Directives? □ Yes □ No, but like to request information □ No, and declines information |

INSURANCE INFORMATION(Please give your insurance card to the receptionist)

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| Person responsible for bill: Home Phone: |
| Address (if different):  |

Please indicate primary insurance: □ EAP

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| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: |
| Policy or Medicaid No: | Group No: | Co-payment: |

Patient’s relationship to subscriber: Please indicate secondary insurance (if applicable):

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| --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: |
| Policy or Medicaid No: | Group No: |  |

Patient’s relationship to subscriber: PRIMARY CARE PHYSICIAN

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| Name of Primary Care Physician: □ Do not have onePhysician Address: Phone number:  |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Horizons Mental Health Agency. I understand that I am financially responsible for any balance. I also authorize New Horizons Mental Health Services or insurance company to release any information required to process my claims.

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|  | Patient/Guardian signature |  | Date |  |

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