MALE BEHAVIORAL HEALTH

CLIENT INFORMATION:

Patient Name: _____ DOB: / / AGE: _____ SOCIAL SECURITY # _____-_____-_____

Address: _____

City/State/Zip: _____

Work Phone: _____ Cell Phone: _____ E-mail: _____

PSYCHIATRIC HISTORY:

Is there any family history of Mental Health Disorders? If so, please explain: _____

Do you have any history of suicide attempts? If so, please explain _____

Past Psychiatric/Psychological Treatment History:

Individual Outpatient Therapy_____
Family/Marital Therapy _____
Partial/IOP Hospitalization _____
Medication Management_____
Inpatient Hospitalization _____

EMERGENCY CONTACT INFORMATION:

Name/Relationship:

_____

Street Address: _____City: _____ State: _____ Zip:
Home Phone: _____ Cell Phone: _____ Work Phone: ___

FINANCIAL INFORMATION:

Employer: _____Employer phone: _____

Primary Insurance Company: _____

Identification Number on Card_____

Group Number (if applicable): _____

Subscriber Name: _____

Person who holds the policy Subscriber's Social Security Number:____ - ____ - _____

Subscriber's Phone:_____ Cell: _____

Subscriber's Address: _____

ADDRESS
457 Waterbury Ct, Suite G,
Gahanna, OH 432305

CONTACT
T: (614) 360-9702
E: info@mbhinc.com
W: www.mbhinc.com

City: _____ State: ____ Zip: _____ Subscriber's DOB: ____/_____/_____

- PLEASE BRING ALL INSURANCE INFORMATION TO FIRST APPOINTMENT

CLIENT SERVICE AGREEMENT

APPOINTMENTS AND FEES:

Initial Psychiatric Evaluation (60 min): $115

Psychotherapy(60 min): $100

Insurance health benefits may not cover all session fees. As a result, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. We Accept the following insurance plans: **BCBS, Buckeye, CareSource**,**Medicaid**, **Medical Mutual, Medicare, Molina**, **Paramount**, and **UHC Medicaid/Medicare. More insurance panels are being added so check back regularly.**

Payment for service is expected at the end of each session. A returned check fee of $25.00 will also be charged for all dishonored checks.

CANCELLATIONS AND NO-SHOWS:

"No Show" appointments and cancellations with less than 24 hour notice will be billed to you at the full fee. Your insurance company will not reimburse you for this. Exceptions to the 24 hour notice policy would include a specified emergency or if the appointment can be filled in your absence, but still subject to 50% of the full fee.

EMERGENCIES AND AFTER HOURS:

Voicemail will be checked frequently throughout the day and at least once on weekends. Calls will be returned as soon as possible. You are also welcome to leave a voicemail. In the event of an emergency, please call 911 or go to your nearest emergency department.

I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is more than 60 days in arrears, I authorize that pertinent billing information can be released to a professional service for purpose of collection of the outstanding balances.

Signature (Patient/Guardian): _____

Date: _____

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