

PATIENT INFORMATION			ACCOUNT #:			Date: _____			
Patients Legal Name (Last, First, Middle)						Preferred Name			
Social Security Number			Date of Birth		Sex: Male Female		Home Phone Number		
The child lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Guardian(s): _____									
Preferred Notification Method: <input type="checkbox"/> Postal Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Web Message									
Mother / Guardian(s) Name:				Father / Guardian(s) Name:					
Date of Birth		Sex	SSN		Date of Birth		Sex	SSN	
Address				Address					
City			State	Zip	City			State / Zip	
Home Phone		Cell Phone			Home Phone		Cell Phone		
Work Phone		E-Mail Address:			Work Phone		E-Mail Address:		
Employer Name				Employer Name					
PRIMARY			INSURANCE INFORMATION			SECONDARY / SUPPLEMENTAL			
Name of Plan				Name of Plan					
Claims Address (Street Address/P.O. Box)				Claims Address (Street Address/P.O. Box)					
City			State	Zip	City			State / Zip	
Phone Number				Phone Number					
Patient Policy Number			Group Number		Patient Policy Number			Group Number	
Subscriber Name (if different from patient): (Last, First, MI)				Subscriber Name (if different from patient): (L, F, MI)					
Subscriber Sex : <input type="checkbox"/> M <input type="checkbox"/> F		Subscriber Policy #:		Subscriber Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Subscriber Policy #:			
Guarantor Employer Name				Guarantor Employer Name					
Effective Date			Expiration Date		Effective Date			Expiration Date	
Copoly Amount \$		Relationship to child			Copoly Amount \$		Relationship to child		
Plan Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Self Pay				Plan Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Self Pay					
Person Responsible for Payment of Bill: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian or Other _____									

EMERGENCY CONTACT: (Other than Mother or Father)			
Name (Last, First, Middle)		Relationship	
Home Phone Number	Work Phone Number	Cell Phone Number	

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I guarantee payment to GFHS and its affiliates for all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical, surgical and behavioral benefits, which would otherwise be payable to me, to GFHS Inc for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIX of the Social Security Act is correct.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION

I voluntarily consent to healthcare treatment (i.e., physical and/or behavioral treatment) from the physicians, behavioral health providers, and staff of GFHS, inc. I consent to any necessary lab work, including HIV testing. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that GFHS employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between GFHS providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I certify that I have read and understand this form.

Signed: _____ Date: ____ / ____ / ____

Office Use Only:

Witness Signature	Date / Time
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General Comment Section

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter accepted _____ Interpreter Refused

Name /Number of Person/services chosen/used