GUARANTOR INFORMATION (THE GUARANTOR IS THE PERSON WHO WILL RECEIVE AND BE RESPONSIBLE FOR THE BILL)

LAST NAME: ______________________________________ FIRST NAME: _______________________________________ MIDDLE INITIAL: _____

ADDRESS: ____ CITY: __________________________ STATE: ______ ZIP: ____________

EMPLOYMENT: ☐ EMPLOYED ☐ FULL TIME STUDENT ☐ PART TIME STUDENT ☐ OTHER

GENDER: ☐ MALE ☐ FEMALE

HOME PHONE:______________________________ WORK PHONE:______________________________ DATE OF BIRTH: __________________

SOCIAL SECURITY #:_____________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

IS GUARANTOR A CPMH PATIENT: ☐ YES ☐ NO

WHO REFERRED YOU TO CAROLINA PARTNERS? ____

EMPLOYER COMPANY: ____ EMPLOYER PHONE #: ____________________________________

EMPLOYER ADDRESS: ____ CITY: ________________________ STATE: ______ ZIP: ____________

DEPENDENT INFORMATION (THIS SECTION CONTAINS INFORMATION ABOUT THE CLIENT. IF THE CLIENT IS THE SAME PERSON AS THE GUARANTOR, THEN PROCEED TO INSURANCE INFORMATION.)

LAST NAME: ____ FIRST NAME: __________________________________ MIDDLE INITIAL: _____

DATE OF BIRTH: ___________________________ RELATIONSHIP TO THE GUARANTOR: ____

GENDER: ☐ MALE ☐ FEMALE DEPENDENT'S SOCIAL SECURITY#: ____

DEPENDENT ADDRESS:_________________________________ CITY: _______________________________ STATE: _______ ZIP: __________

HOME PHONE: __________________________ WORK PHONE: _________________________ MARITAL STATUS: ☐ SINGLE ☐ MARRIED

WORK: ☐ EMPLOYED ☐ P/T STUDENT ☐ F/T STUDENT ☐ OTHER

EMPLOYER COMPANY: ____________________________ PHONE #: _____________________

COMPANY ADDRESS:___________________________________ CITY: _______________________________ STATE: _______ ZIP: __________

PATIENT'S PRIMARY CARE DOCTOR

PRIMARY CARE DOCTOR: ____ PHONE #: _______________________________________

DOCTOR'S ADDRESS:__________________________________ CITY: _______________________________ STATE: _______ ZIP: __________

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY: _______________________________________ INSURANCE ID NUMBER OF THE **PATIENT:** _______________________

INSURANCE ADDRESS:_________________________________ CITY: _______________________________ STATE: _______ ZIP: __________

INSURANCE CO PHONE: ____

GROUP NAME OR NUMBER: ____

POLICY DATES: FROM: ____________ TO: ____________

EMPLOYER PLAN: ☐ YES ☐ NO **INSURED PARTY NAME:** ____

INSURED PARTY ADDRESS: ____ CITY: ____________________________ STATE: _____ ZIP: _______

INSURED PARTY PHONE: ____

INSURED PARTY SOCIAL SECURITY NUMBER: ________________________________ **INSURED PARTY** DATE OF BIRTH: _____________

EMERGENCY CONTACT NAME: ____ PHONE NUMBER: ____________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:

SIGNATURE: DATE:

I hereby authorize payment directly to the physician of the surgical and/pr 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.

I have read the Policy and Procedures and understand and accept the policies described above. I would rather:

☐ Pay each visit in full (and file my own insurance)

☐ Pay my insurance co-payment and other fees each session and have my insurance filed for me

☐ Make an alternative plan that must be specific and accepted by Carolina Partners in Mental HealthCare, P.L.L.C. This option needs to be discussed with your clinician and approved in order to take effect.

Client's Name: ____

Client's Signature:______________________ Date:__________

Clinician's Signature:____________________ Date:__________

Witness:______________________________ Date:__________

INSURANCE AUTHORIZATION

IN ORDER THAT WE MAY FILE YOUR INSURANCE FOR YOU, PLEASE CHECK EACH BOX AND SIGN THE FOLLOWING SIGNATURE-ON-FILE FORM

☐ I authorize use of this form on all my insurance submissions.

☐ I authorize release of information to all my insurance carriers.

☐ I understand that I am responsible for my bill.

☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

☐ I authorize payment directly to my doctor or other health care provider, and hereby assign my right to reimbursement for services rendered to Carolina Partners in Mental HealthCare, P.L.L.C.

☐ I permit a copy of this authorization to be used in place of the original.

Signature: ____________________________ Date: __________________