Patient Information

Patient Name: _____ Sex: M◉ F◯ Age: ____ DOB: ___/___/___

Patient Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Physician Name: _____ Phone: _____

Language the patient speaks better: _____

Patient Consent for Evaluation and Treatment

I give consent to ARLEY MENTAL HEALTH to do the following:

☐ Evaluate and treat Mental Health

This permission is good enough while at ARLEY MENTAL HEALTH concerning the care and treatment of the above-named patient.

_____ _____ _____

Patient Name Patient Signature Date

Patient Consent to Release Information

I give permission to ARLEY MENTAL HEALTH to communicate without restraint with the above-named physician, related health professionals, family members, insurance companies, billing offices as deemed fit and in the sole discretion of ARLEY MENTAL HEALTH concerning the care and treatment of the above-named patient.

_____ _____ _____

Patient Name Patient Signature Date

Insurance Information

☐ Medicaid ☐ Medicaid/HMO ☐ Other_____

ID #:_____ Social Security #:_____ DOB:____/____/____

I authorize ARLEY MENTAL HEALTH to release all information needed for related Medicaid, or any other insurance holder, to the social security administration or its intermediaries or carriers. I permit a copy of my authorization to be used in place of the original.

I hereby authorize payment if any, to be paid directly to ARLEY MENTAL HEALTH S for medical benefits. If for any reason full payment is not received, I accept full responsibility to pay whatever charges remain. If do not pay such charges and it becomes necessary for you to file suit against me to collect such charges, I agree to pay for a reasonably attorney fee and the cost of the collection.

_____ _____ _____

Patient Name Patient Signature Date