Cognizant Behavioral Health Services

Date___________

Patient Information

Patient Name: _________________________________ DOB____________ Age_______________________
SSN______-________-_______
Home Phone :(_____) _____-_________ Cell Phone: (____) _____-______________________________
Address: ____ ____________________
City: ____________________________________ State: _________ Zip Code:_____________ _________________
Email address (used for appointment reminders):___________________________________ _________________
Phone Number (used for appointment reminders):____________________________________ ________________
Employer/School: ___________________________________ Occupation: _________________________________
Employer Address: ____
City: ____________________________________ State: _________ Zip Code: ______________________________

Emergency Contact

Emergency Contact: _________________________________ Relation to Patient___________________________
Contact Phone Number: ____
Spouse/partner or Parent (if patient is under 18 years old) ____
Spouse/partner or Parent Phone Number: __________________DOB:__________ Age: ______________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

In regard To Patient: _____________________________________DOB:________________________
I____________________________________, hereby consent and authorize providers at CBHS to release protected health information related to my evaluation and treatment to:

My Physician____Phone____________________
Address______________________________________ _____________ ___________ __________
(Street) (City) (State) (Zip code)

PATIENT RIGHTS

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with this request. I understand that authorizing the disclosure of this information is Voluntary and that I need not sign this authorization in order to receive treatment.
I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.
This consent will expire automatically 90 days form termination of treatment

PATIENT RESPONSIBILTIES

I verify that the above information is factual and true to the best of my knowledge. I understand that payment, proof of insurance, and/or copay is due at the time of service.
I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct. Co-ordination of benefits is my responsibility.
Cognizant Behavioral Health Services will make an attempt to send a courtesy e-mail in advance as appointment reminders.

____ ____________________
Patient (patient representative/guardian's) Signature Date