

**HERITAGE BEHAVIORAL HEALTH CENTER**  
**2485 E. Southlake Blvd. Ste. 180**  
**Southlake, Texas 76092**  
**817-488-9697**

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**We request that you provide us with the following information which will be used for professional purposes only and will remain confidential.**

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Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Your Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Is it okay to mail correspondence to this address? Yes \_\_\_\_\_ No \_\_\_\_\_  
If no, is there another address for mailing? \_\_\_\_\_

Client's SS#: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Client's Employer: \_\_\_\_\_ Client's Occupation: \_\_\_\_\_  
Home Ph:( ) \_\_\_\_\_ Work Ph: ( ) \_\_\_\_\_ Cell( ) \_\_\_\_\_  
May we leave a brief message at home? \_\_\_\_\_ At work? \_\_\_\_\_ Cell? \_\_\_\_\_  
(No detailed messages will be left at work, we will just leave a name & number if you're not immediately available)  
Spouse's/Partner's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ His/Her SS#: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone #: \_\_\_\_\_  
Type of Plan: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Is there a Secondary Policy? \_\_\_\_\_ If so, Name of Insured, Co. Name & SS# of Insured: \_\_\_\_\_

Reason for coming in: \_\_\_\_\_

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Referred by: \_\_\_\_\_ Previous Treatment(Y/N) \_\_\_\_\_  
Previous Therapists \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_



**PLEASE READ THE FOLLOWING CAREFULLY:**

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Heritage Behavioral Health Center will honor contractual agreements made with those managed health care companies and Employee Assistance Programs which stipulate specific reimbursement restrictions.

**I realize that I will be charged \$75.00 for appointments not canceled within 24 hours of the appointment time.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**How to benefit from therapy.....**

Therapy is the Greek word for change. The success of our work together depends upon the quality of the efforts on both our parts, and the realization that you are responsible for life style choices/changes that may result from therapy. I hereby consent to treatment by the specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have the right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize the release of necessary medical information for insurance or EAP reimbursement purposes.

X \_\_\_\_\_ Date \_\_\_\_\_

I authorize the payment of medical benefits to the provider of services.

X \_\_\_\_\_ Date \_\_\_\_\_