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

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

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:_____
_____
_____
Referred by:_____Previous Treatment(Y/N)_____
Previous Therapists_____Dates:_____to_____
_____Dates:_____to_____

Please turn over to complete this form with your signature

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 $90.00 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 reimbursement purposes.

X_____Date_____

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

X_____Date_____