



Integrative Therapies LLC

Registration Form

Date: \_\_\_\_\_

PATIENT INFORMATION

NAME: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT: \_\_\_\_\_

INSURANCE INFORMATION

Subscriber: (Self) (Spouse) (Parent) (other) Name of Subscriber: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

\*\*\*Please note: If your mental health benefits are carved out to UBH(United Behavioral Health) UBH will not recognize your medical policy number; for mental health authorization and billing purposes you will need to provide your Social Security # or the subscriber's SS#-- Please understand that this information is secure and protected under the Health Information Protection Act\*\*\*

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Managed Plan: Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ # of Sessions in Benefit Plan \_\_\_\_\_ Co-pay =\$ \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

\*\*For NHP/BHS (Neighborhood Health Plan/ Beacon Health Strategies) members it is a requirement that you provide the number of out-patient visits used during your calendar year—it is ultimately your responsibility to ensure that you have not exceeded your benefit limit\*\*\*

Number of out-patient Mental Health visits/sessions used during calender year: \_\_\_\_\_

Dates of sessions: \_\_\_\_\_

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO INSURANCE COMPANY

I hereby authorize Integrative Therapies, LLC to furnish Protected Health Information to my health insurance company for the purposes of authorizing care, filing claims for payment or complying with insurance company requirements regarding the management of my care.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date

Please see reverse side

**REFERRAL INFORMATION**

How were you referred? \_\_\_\_\_

Have you been given a diagnosis? \_\_\_\_\_

Name of Diagnosing doctor/clinician \_\_\_\_\_ Year(s) treated \_\_\_\_\_

What type of treatment have you sought for the diagnosis? \_\_\_\_\_

\_\_\_\_\_

Are you currently on any psychotropic medication? Anxiety? Mood stabilizer? Depression Medication?

Current Medications/Dose: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who prescribes the medication (PCP/Psychiatrist)? \_\_\_\_\_

\*\*\* For coordination of care purposes:

May I contact the prescriber? \_\_\_\_\_ Contact number for treating prescriber? \_\_\_\_\_

(If answers are all "no" to the above questions please answer, the following question)

Reason for Seeking Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_