THERAPY INSTITUTE OF MICHIGAN LLC

Helping You Build A Life Worth Living

Client Registration and Financial Information Form

I truly appreciate your choosing Therapy Institute of Michigan, LLC for your mental health treatment. Please complete the client registration and financial information form. If you have any questions we will be happy to assist you with the form.

• If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, my staff and I need the information requested below. We will explain any part of this form that you do not understand.

• If you have no health insurance coverage, or do not intend to use it, please check here ❑, complete sections A and E below, and return this form to me or my secretary.

A. Patient's name: _____ Birthdate: _____Soc. Sec. #: _____

Address: _____Home phone: _____

Cell Phone:_____ Can we leave messages on the phone listed? _____

Email Address:_____ Do you give permission to text or email for scheduling? _____

(If the patient is a dependent) Insured's/policy holder's name: _____

(If minor's parents are divorced, provide a copy of legal documents to show who has legal custody)

Occupation:_____ Employer: _____ Work phone: _____

Address of employer:_____

Emergency Contact: _____Phone:_____

B. (If applicable) Spouse's name: _____Birthdate: _____ Soc. Sec. #: _____

Occupation: _____Employer: _____ Work phone: _____

Address of employer:_____

Spouse Address: _____ Home Phone: _____

Note: Copayments by you are required at the time of service.

C. If you (or your spouse) have any of these kinds of insurance, please fill in the numbers and names for each one.

1. **Blue Cross/Blue Shield**

Name of subscriber (if not the patient): _____

Identification/agreement/policy #: _____Group or enrollment #: _____

Plan #/code or BS #: _____ Effective date: _____

Location of plan: _____ Reciprocity #: _____

Phone: _____ Other information: _____

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2. Commercial health insurance carrier/company

Name of company: _____

Name of policyholder (if not the patient): _____

Policy #: _____ Certificate #: _____

Phone: _____ Address to send claims: _____

6. Workers' compensation insurance

Name of company: _____Policy #: _____Certificate #: _____

Address to send claims: _____

Phone: _____ Treatment authorized by: _____Date of injury: _____

Do you or your spouse have any other insurance coverage that applies here (motor vehicle insurance for an injury, etc.)? If yes, check here ❑ and fill in an empty section above.

D. For each kind of insurance you intend to use, please provide the following information. If you are unsure, we can assist in completing this form. If you are private pay, please do not complete this section.

1. Company: _____ Effective date of coverage: _____

Deductible: $ _____ ❑ per person or ❑ per family? or ❑ per diagnosis?

❑ per fiscal year or ❑ per calendar year or ❑ per policy year?

How much of this deductible has been used so far? $ ____

Benefit: _____ %of ❑ charges ❑ Usual, customary, and reasonable (UCR) ❑ Maximum charge of $ _____

❑ Other benefits:

Percent reduction, if any, for mental health? _____ %

Limitations: Number of visits: ___ Monetary limits: $ _____ per _____ Lifetime limits: $ _____

Is outpatient group psychotherapy covered? ❑ Yes ❑ No

Does any rule about preexisting conditions apply here? ❑ No ❑ Yes, and the rule is: _____

Are there any other limitations (such as conditions not covered, service settings, maximum per-session charges, need for DSM or ICD diagnostic codes or CPT service codes)? _____

_____

E. Will you be using insurance or private pay for services? _____

F. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

G. I understand that I am responsible for all charges, regardless of insurance coverage.

H. I hereby authorize payment directly to the Therapy Institute of Michigan (TIOMLLC), LLC, of all insurance benefits otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not paid by insurance, for all services on my behalf or my dependents. I understand that insurance Explanation of Benefits (EOB) will be sent to the policy holder and may include service information. I authorize the above providers/supplier of services at TIOMLLC to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that therapists are mandated reporters and in the event of harm or threat of harm to myself or others they are required by law to report this information. I understand that in the event of suicidal threat and/or intent my therapist will need to contact my designated contact person and/or local authorities.

_____ _____
Client's (or parent/guardian's) signature, Date
Indicating agreement to all of the statements above

_____
Printed name

Staff signature with credentials: _____Date:_____