MENTAL HEALTH AFFILIATES

1290 Worcester Road
Framingham, MA 01702
(508) 872-1650
Fax: (508) 370-7282

221 Boston Post Road, East, #450
Marlborough, MA 01752
(508) 460-9633
Fax: (508) 481-2608

PATIENT/CLIENT'S NAME: _____
last first middle initial

ADDRESS: _____

_____

PHONE: (home) _____ (work) _____ (cell) _____

Date of Birth: _____ Age: _____ Male _____ Female _____ Marital Status: _____

EMPLOYER: _____ REFERRED BY: _____

EMAIL: _____ EMERGENCY CONTACT: _____

HEALTH INSURANCE COMPANY: _____

ID #: _____ GROUP #: _____ SOCIAL SECURITY #: _____

Auth # _____ # Sessions approved _____ Effective dates _____ Co-pay $_____

INSURANCE SUBSCRIBER INFORMATION (IF DIFFERENT FROM PATIENT):

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ DATE OF BIRTH: _____ Male _____ Female _____

_____ PHONE: _____ SOCIAL SECURITY # _____

I authorize the release of information required by my health insurance company that is necessary under my contract for authorization updates, to submit claims on my behalf and to pursue claim payments. I understand that Mental Health Affiliates utilizes a billing person who may interact with my insurance company. This billing person is also bound by state and federal rules of confidentiality.

All personal balances are payable at the end of each session or at the last session of the month. All efforts will be made to work with your insurance coverage; however, the above named is responsible for all charges not paid by the insurance company under the terms of their contract. There will be a charge for missed appointments and/or late cancellations with less than 24 hours notice. Concerns or complaints regarding services rendered may be expressed in writing or verbally.

I acknowledge that I have been made aware of the HIPPA policy and have been offered a copy of it._____
Initial

SIGNATURE: _____ DATE: _____

Office use: Acct # _____ Therapist: _____ Dx: _____

(rev. 11/12)