Columbia County Mental Health Center

Client Information

Client's Name (First-Last-Middle) _____

Date of Birth _____ Age _____ Sex_____ Social Security # _____

Responsible Party if Client is a Minor _____

Physical Address: Street _____ City_____ State _____ Zip _____

Mailing Address (if different than Physical) _____

Town of _____ Is Patient a Columbia County Resident? Yes ☐ No ☐

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Email Address _____

Insurance Information

Primary Insurance Company Name _____

Please Circle HMO PPO Other _____

Policy ID Number_____ Group Number_____ Phone _____

Name of Insured _____ Insured Date of Birth _____

Relationship of Insured to Client _____

Secondary Insurance Company Name_____

Please Circle HMO PPO Other _____

Policy ID Number_____ Group Number_____ Phone _____

Name of Insured _____ Insured Date of Birth _____

Relationship of Insured to Client _____

YOU MUST PROVIDE INSURANCE INFORMATION TO ESTABLISH YOUR CO-PAY. IF YOU DO NOT HAVE INSURANCE, YOU MUST PROVIDE DOCUMENTATION OF INCOME TO DETERMINE YOUR FEE. IF YOU DO NOT PROVIDE INSURANCE OR INCOME INFORMATION, YOU WILL BE CHARGED THE FULL COST OF SERVICE. FAILURE TO PAY MAY RESULT IN A REDUCTION OF SERVICES.

I request that payment of authorized benefits be made on my behalf to Columbia County Mental Health Center for services furnished to me by the provider. I authorize Columbia County Mental Health Center to release to the above insurance carriers, Medicaid or Medicare any medical or other information necessary to process my insurance claims.

Signature of Client *(or legal representative if client is a minor)* Date