THE CENTER for Mental Health
Providing Help, Hope, and Healing

NEW CLIENT INFORMATION

Client #:	Admit Date:

CLIENT INFORMATION:

Name: _____ Who Were You Referred by: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

S.S.#: _____ Birthdate: _____ Age: _____ Client is under age 13: _____

Birth Gender: _____ Preferred Pronoun(s): _____

Home Phone: _____ OK for CMH to I.D? _____Yes _____No

Cell Phone: _____ OK for CMH to I.D? _____Yes _____No

Email Address: _____ OK for CMH to I.D? _____Yes _____No

APPOINTMENT REMINDERS: How would you like to receive reminders for your appointments?

Phone Number: _____ Text Number: _____

May we leave a message with whoever answers the phone? _____Yes _____No

May we leave a message on the answering machine? _____Yes _____No

Email Address: _____

I do not wish to be reminded of my appointments: _____ (Please initial)

GENERAL INFORMATION:

Ethnicity: White/Caucasian _____ American Indian/Alaskan Native _____ Asian _____

Black/ African American _____ Hispanic (Puerto Rican _____ Mexican _____ Cuban _____ Other _____)

Primary Language: English _____ Spanish _____ Other _____

Military Veteran: Yes _____ No _____ Smoking Status: Current _____ Former _____ Never _____

FINANCIAL INFORMATION: ***PLEASE PROVIDE YOUR INSURANCE CARD***

ANNUAL INCOME: _____ NUMBER IN HOUSEHOLD (supported by income): _____

PAYER: Self: _____ Medicare#: _____ Medicaid #: _____

Private Insurance (Type/#): _____ Other (Type/#): _____

GUARANTOR: Name: _____ Relationship: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

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ACKNOWLEDGEMENTS:

A. I hereby apply for services for myself and/or my dependents at Midwestern Colorado Mental Health Center, dba The Center for Mental Health. _____(Please initial)

B. I attest that:

1.) I understand that payment must be made at the time of service. _____(Please initial)

2.) I have been given a sheet entitled "INFORMATION REGARDING YOUR TREATMENT" that describes my therapist/provider's qualifications. _____(Please initial)

I authorize payment of third-party benefits directly to The Center for Mental Health for services rendered for myself and/or my dependents. I further authorize The Center for Mental Health to release all information with respect to myself or my dependents as may be required to process claims for payment for services provided. I authorize my insurance company or "provider" to release to The Center for Mental Health any information regarding my claims or claims of my dependents for services rendered. I understand that am ultimately financially responsible to the Center for Mental Health for any monies paid directly to me or my insurance company or other "payee," and for any other services not covered by my insurance or "payee.

" If you are filling out this document electronically, please select the appropriate box below:

☐ I intend that this document may be signed in electronic form and that my signature to this document is provided by electronic means.

☐ The parties intend that this document may be signed in electronic form and that all signatures to this document may be provided by electronic means

CLIENT OR RESPONSIBLE PARTY SIGNATURE	**DATE**