BCSGroup
Integrated Mental & Emotional well-being

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PATIENT REGISTRATION FORM

COUNSELOR'S NAME: _____

Brooklyn Women's Counseling Services complies with the medical privacy regulations issued by the U.S. Department of Health & Human Services under the Health Insurance and Portability & Accountability Act (HIPAA) of 1996.

YOUR NAME: _____

☐ Female ☐ Male DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Please indicate your preferred method of contact:

HOME PHONE: (___) _____ CELL: (___) _____ WORK PHONE: (___) _____

EMAIL: _____

MARITAL STATUS: _____ SSN: _____

WORK STATUS: ☐ Ful-ltime ☐ Part-time ☐ Retired ☐ Student ☐ Other: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____

PRIMARY INSURANCE COMPANY: _____ PHONE: (___) _____

ID# _____ GROUP# _____ PLAN# _____

RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

NAME OF INSURED: _____ INSURED'S DOB: _____

SECONDARY INSURANCE COMPANY: _____ PHONE: (___) _____

ID# _____ GROUP# _____ PLAN# _____

RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

NAME OF INSURED: _____ INSURED'S DOB: _____

Whom may we thank for referring you?

☐ Friend: _____ ☐ Event: _____ ☐ Insurance: _____

☐ Physician: _____ ☐ Advertisement: _____ ☐ Yellow Pages ☐ Mailing

☐ Walk-in ☐ Our Website ☐ Maimonides Medical Center ☐ Other: _____

EMERGENCY CONTACT: _____ PHONE: (___) _____

RELATIONSHIP: _____

These providers are authorized to render services(s) to the undersigned and/or her/his dependent(s). I also authorize payment of insurance benefits when assignable to be made on my behalf to provider for services rendered. I understand eligibility must me verified for assigned insurance benefits and that charges during a lapse, in benefits, deductible periods, and coinsurance are my responsibility. I authorize Government benefits to Brooklyn Women's Services. I authorize photocopies of this form to be as valid as the original.

I authorize members and associates of these provider groups access to my medical record for the purpose of coordination of my medical care. I authorize release of information regarding medical treatment and related information to my health insurance company, Health Care Financing Administration, their authorized agents or intermediaries for the purpose of validating and determining benefits payable.

I authorize Brooklyn Women's Services staff to contact me and/or leave a message at the address, phone numbers and/or email address(es) provided above.

SIGNATURE: _____ DATE: _____

PATIENT / PARENT / GUARDIAN / AUTHORIZED REPRESENTATIVE