Behavioral
Health Services of Atlanta

Patient Demographic Information

Patient Name:	Allergies/Medical Alerts:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender:	Work Phone:
Email Address:	Mobile Phone:
Primary Physician:	Psychiatrist (if any):
Emergency Contact Person:	Emergency Contact Phone:
How did you hear about us?	Marital Status:

In the case of a medical or psychiatric emergency I authorize Anthea Johnson, or a representative of Behavioral Health Services of Atlanta, LLC to contact my emergency contact.
Signature: ____
Date: _______________________

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Insurance Information

Client Name____________________

Primary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**
Secondary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**

I authorize Anthea M Johnson or a representative of Behavioral Health Services of Atlanta, LLC to contact my insurance provider for the purpose of submitting all information and claims as it relates to services provide by Behavioral Health Services of Atlanta, LLC, including but not limited to: Verifying Benefits, Prior Authorizations, Providing Necessary Information for Approval of Continued Care and Submitting Claims for Billing.
I further understand that I am financially responsible for any portion of my services that are not paid by the insurance company.

Signature: ____
Date: ___________________________

I verify that all of the information I have provided is true and accurate to the best of my knowledge.

Signature: ______________________________
Date: ___________________________