Section I-Patient Information

Last Name	First Name	Middle Initial	Gender/Preferred Pronouns

☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Last 4 of SS# XXX-XX-	Date of Birth

Home Address City State Zip	Race/Ethnicity

Home Phone	Cell Phone	May we leave messages regarding appointments? Yes ___ No ___	Email Address

Current Employer	Occupation	Current Work Phone #

Current Employer's Address/Location	Interpreter Name/CO (if applicable)	Interpreter Phone #

Is this visit related to a **work** injury? Yes ___ No ___ If yes, date of injury: _____ and complete Sections II, V, & VI.
Is this visit related to an **auto** injury? Yes ___ No ___ If yes, date of accident: _____ and complete Sections III, V, & VI.
If this visit is **not** related to either of the above, please complete Sections V & VI, and initial/sign at the bottom (both boxes).

Section II-Worker's Compensation Information
(Must be completed in order to bill Worker's Compensation claims)

Employer at time of injury (if different from above)	Employer's address/City/State/Zip (if different from above)	
Insurance Company's Name	Claim/Subscriber Number	Main Phone Number
Name of Adjustor or Claims Representative	Adjustor's Phone	Adjustor's Fax
Name of Nurse Case Manager (if applicable)	Case Manager's Phone	Case Manager's Fax
Primary Claim Address/City/State/Zip		Primary Claim Phone

Section III-Auto Insurance Information
(Must be completed in order to bill Auto Insurance claims)

Insurance Company's Name	Insurance Company's Address/City/State/Zip	
Adjustor's Name	Adjustor's Phone Number	Claim Number

Section IV-Commercial (Primary) Insurance Information
(Please note: the Behavioral Medicine Center does not accept any Commercial Insurance plans at this time.)

Insurance Company's Name	Address City/State/Zip		Phone
Co-pay amount	Policy Holder's Last Name	First Name	Relationship
Type of Coverage (HMO, POS, PPO, etc.)	Group Number	ID or Member Number	

Section V-Referral Source

Referred By	Referral Source Phone	Referral Source Fax

Section VI-Emergency Contact Information (Required for Telehealth)

Name	Phone	Relationship	May we contact this person in case of emergency? Yes_____ No_____

Authorization of Payment for Services: *Please initial one*

_____ If using insurance (including Work Comp): I authorize payment of benefits directly to the Behavioral Medicine Center for services provided by Rebecca Hawkins, PhD, PC.

_____ If not using insurance: I agree to pay at the time of service in accordance with the fee schedule I have been provided for services provided by Rebecca Hawkins, PhD, PC.

A photocopy of this authorization shall be as valid as the original.

X_____ _____

Signature Date

Authorization for Release of Records: *Please initial one*

_____ Work-Related Condition or Injury: I authorize the release of any medical or other information necessary to process claims pertaining to my occupational injury claim.

_____ Non-work Related Illness or Injury: I authorize the release of any medical or other information necessary to process claims for services provided. I also agree to pay all outstanding balances not covered by my insurance plan, as well as reasonable fees if my account is turned over to collections for nonpayment.

X_____ _____

Signature Date