Personal Information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

State:

Zip:

Home : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_

Children/Adolescents:

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_

Primary Residence With \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/ Parents : Dad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status Married Single Separated Divorced Widowed

PrimaryPhysician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ofce\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician/Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Guarantor of Patient Under 18 Years of Age

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization to Release Information: I authorize Dr Saurabh Gupta to release any

information necessary, acquired in the course of my treatment, to process insurance claims.

Authorization to Pay Beneﬁts Directly: Health insurance is a contract between you

and an insurance company. As such, it is your responsibility to determine if the services

provided by Dr Saurabh Gupta are covered and to what extent they are covered. By initializing

here, you understand that you will be responsible for all non-covered charges. You are

authorizing your insurance company to pay Dr Saurabh Gupta directly for medical services

rendered, and you hereby assign all such policy beneﬁts to Focus Behavioral Health. \*Initial

Notice of Privacy Practices: I acknowledge that Dr Saurabh Gupta has adopted a

notice of privacy practices. I also understand that I have an opportunity to view that notice.

Financial Policy: Unless covered by medical insurance, payment is due, in full, at the time

services are rendered.

\*Initial Here

Medical Record Release: I hereby authorize any licensed physician, medical

practitioner, therapist, or any other medically related facility, or other organization or person

that has any records or knowledge of my health, to give to Dr Saurabh Gupta, any such

information, if so requested. \*Initial Here

I have read the ofce policy and agree to follow the terms and service \*Initial Here \_\_\_\_\_\_\_\_\_\_\_

Authorizations

OR, I am requesting a copy of the ofce policy to be printed for my own records \*Initial

Date:

We Do Not Accept Workers Compensation or No Fault Claim