Barstow Acres Children's Center, Inc.
590 Main St. Prince Frederick, MD 20678 • 410-414-9901
Barstow.acrescc@yahoo.com

Section I - Patient Information

Name _____
Address _____
City _____ State_____ Zip_____
Home Phone _____ Work/Cell Phone_____
Date of Birth ____/____/_____ Social Security Number_____-_____-_____
Marital Status _____ Gender (circle one) Male Female
Employer or School _____ Employment Status (circle one) Full time Part time
Referred By _____ Self-Employed Student

Section II -Responsible Party Information (Complete if not the patient)

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____
Name _____
Address _____
City _____ State_____ Zip_____
Home Phone_____ Work Phone_____
Date of Birth ____/____/_____ Social Security Number_____-_____-_____
Marital Status _____ Gender (circle one) Male Female
Employer or School _____ Employment Status (circle one) Full time Part time Self

Section III - Insurance Policy Information

Policy Holder Name_____
Insurance Company _____
Policy Holder Date of Birth _____
Policy Number_____
Group Number_____
Is the patient covered by more than one insurance plan? ☐ Yes - Please complete the next section ☐ No

Section IV - Secondary Insurance Policy Information

Policy Holder Name_____
Insurance Company _____
Policy Number_____
Group Number_____

Section V - Sliding Scale Client Information

For Sliding Scale Clients Only: Annual Gross Income $ _____ # Household Members _____

See other side

Section VI - Authorization for Assignment of Insurance Benefits and Release of Information

I hereby authorize Barstow Acres Children's Center to apply for benefits on my behalf and I authorize payment by my insurance company to be made directly to Barstow Acres Children's Center for mental health services provided.
I also authorize Barstow Acres Children's Center to release any necessary information to my insurance carrier and mental health network managing my mental health or substance abuse benefits for the purpose of processing my claims. I also give permission for a copy of this authorization to be used in place of the original and it may be retained on file.

_____ _____

Signature Date

I hereby verify that I have read and received a copy of the HIPAA Notice of Privacy Practices pamphlet.

_____ _____

Signature Date

See other side