InnerView Behavioral Care
MBHC, INC.

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Patient Information

Acct #_____

Legal Name: _____
First Middle Last (Preferred Name)

Address _____
Street Apt.# City State Zip

Telephone # best to reach you @ _____ E-Mail Address _____

Date of Birth_____ SS#_____ Age_____ Gender _____Female _____Male

Trans man_____ Trans woman _____Non-Binary_____, Circle pronouns: She/her He/Him They/Them

_____Married ____Single ____Divorced ____Widowed ____Separated ____Domestic Partnership ____Other

Patient Occupation_____ Employer_____

Spouse/Partner Name_____ D.O.B._____ Spouse/Partner SS#_____
Spouse/Partner Employer_____

Responsible Party_____ Employer _____SS#_____
Address_____ Relationship to Pt_____ D.O.B. _____

Pt. Family Doctor_____ Address_____
Phone_____ Fax_____

Referred By_____ Phone _____

Emergency contact other than spouse/partner_____ Phone_____

I request payment of authorized insurance benefits, including Medicare/Medicare supplements, be made on my behalf to MBHC, INC. for any services furnished to me. I authorize the release of any medical information needed to determine payment of insurance claims. A photocopy of this form shall be considered as effective and valid as the original. I agree to MBHC's rescheduling and cancellations policy stating all appointments must be changed or cancelled within 24 hours or I will be responsible any fees incurred.

All co-pays are due at time of service. All balances must be paid within 120 days unless other arrangements have been made, if no arrangements have been made and account is not paid within 120 days it will be sent to COLLECTION. I understand I am fully liable for any balance not paid by insurance.

Signature_____ Date_____

Witness_____ Date_____

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Care

MBHC, Inc.
27475 Holiday Lane
Perrysburg, OH 43551
419-872-0619

Name: _____

Reason for visit: _____

When did the problem begin? _____

Have you been in therapy before or received any professional assistance for you problem? _____

If so, by whom? _____

Where? _____

Have you ever been hospitalized for psychological/psychiatric problems? _____

If so when: (Dates) _____

Where? _____

Education: _____

Employment (Past and present): _____

List any medical illness(es) you now have: _____

Present Medication: _____

Do you have any allergies? _____ What? _____

Have you or are you now considering harming yourself? _____

Have you or are you now considering harming someone else? _____

Do you have any relative(s) who suffer from medical/emotional problems? _____

If so, please explain: _____

_____

What would you like to achieve from therapy? _____

_____

Date: _____ Signature: _____