InnerView Behavioral Care
MBHC, INC.
Charles S. Burke, M.D.
Ann Hovest, M Ed, LPCC
Jae Kennedy-Cookson APRN-CNP, PMHNP-BC

Patient Information

Acct #_____

Legal Name: _____
First Middle Initial Last (Preferred Name)

Address _____
Street Apt.# City State Zip

Phone # best to reach you @ _____ **E-Mail Address** _____

Date of Birth____/____/_____ **SS#**_____/_____/_____ Age_____ Gender: Female _____Male _____ Other _____

Married _____Single _____ Divorced _____ Widowed _____ Separated _____ Domestic Partnership_____

Pharmacy_____ **Address** _____ **Phone #**_____

Patient Occupation_____ Employer: _____

Ins thru Employer: Yes or No **Name of Ins. Company:** _____

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

Spouse/Partner Ph #_____Spouse/Partner Emp:_____ Ins thru Emp: Yes or No

If yes are you covered under this plan? _____ **Name of Ins.** _____

Resp Party for bal after Ins pays: _____ D.O.B. ____/____/_____ SS# _____/_____/____

Address_____ Relationship to Pt_____ Phone #_____

Emergency contact other than spouse/partner _____

Relationship to Patient _____ **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** _____

InnerView Behavioral 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: _____