PAINTED HORSES, LLC
DEMOGRAPHICS/REFERRAL

Client Name			Date of Birth
Address	City	State	Zip code
Home Phone	Work Phone		Okay to call at work? Y N
Client's Sex Male _____ Female _____	Marital Status: Partnered:_____ Married____ Single_____ Other _____		SS #
PH File	Guardian Name		Guardian Phone
Guardian Address			
Next of Kin Name, Relationship & Address			
Occupation			
School/Grade			
Family Composition			
Medications (Previous)			
Medications (Current)			
Allergies/Drug Interactions			
Are you currently receiving either mental health outpatient therapy or substance abuse services from another provider? Yes_____ No_____ If yes, provider name:_____			

MAINECARE/PRIMECARE

Name	MaineCare Number

OTHER INSURANCE CARRIER

Insurance Provider	Guarantor	
Guarantor Employer	Guarantor SS#	
Policy Number.	Group #	
Insurance Provider Address		Guarantor DOB
City	State/Zip	Telephone #
Co-pay	Referral Needed? Y N	Referral #
Primary Care Physician		Telephone #

BILLING POLICY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO PAINTED HORSES, LLC FOR SERVICES NOT COVERED BY MY INSURANCE, UNLESS I AM ALSO COVERED UNDER MAINECARE. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MISSED APPOINTMENTS IF I HAVE NOT NOTIFIED PAINTED HORSES, LLC 24 HOURS IN ADVANCE.

Cli **Client/Guardian Signature** _____

I HEREBY AUTHORIZE PAINTED HORSES, LLC TO FURNISH INFORMATION REGARDING MY DIAGNOSIS AND TREATMENT TO THE ABOVE INSURANCE CARRIERS AND/OR MAINECARE.

Client **Client/Guardian Signature** _____

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE PERMISSION FOR TREATMENT BY PROVIDERS OF PAINTED HORSES, LLC.

Client/Guardian/Guardian Signature _____