Mountain Dew Behavioral Health PLC

Name: _________________________________ Date of Birth____/______/_____

Gender: _ ________________ Marital Status____________ SSN#_____________

Pharmacy: ____

Contact Information:

Mailing Address: ____

City: ______________________ Zip Code: ____________State:___________

Cell Phone: ___________________________ Home Phone:__________________

Email: ____

Emergency Contact: _________________________________Tel._____________

Insurance Information:

Primary Insurance: ___________________________ ID #______________________

Claims Mailing Address: ____

Phone number________________

Is there a phone number for mental health? Yes or No #____________________

Secondary Insurance: ____

Address: ____

Plan ID#_______________________________ Group #________________________

Phone number:________________________ Employer:_______________________

Have you contacted your insurance about your mental health benefits? Y or N

Have you seen a mental health professional in the last year? Y or N. If so

Where? _________________________How often? ________________________

Authorization to release information: **I certify the information provided is accurate. I hereby authorize the release of any medical information necessary to process my claims. In the event that a dispute arises regarding non-payment for**

services between my doctor and my insurance company, I give permission for the AZ department of insurance to access my medical records if necessary to resolve the matter. I authorize my insurance benefits to be paid to Mountain Dew Behavioral Health. I understand that I am financially responsible for non-covered services.
I authorize the medical team of Mountain Dew Behavioral Health PLC to treat and educate me as related to my medical, mental and psychological conditions.

Signature:____________________________ Date:___________________