Health Affiliates Maine

Outpatient

Demographics

CLINICIAN NAME _____

Client Name		Date of Birth
Primary Language	Do you need an Interpreter? ☐ Y ☐ N	
Address	City	State Zip Code
Home Phone	Work Phone	Okay to call at work? ☐ Y ☐ N
Client's Gender	Client's Marital Status: Partnered ☐ Married ☐ Single ☐ Other ☐	Client's SS #
Guardian Name	Relationship to Client	Guardian Phone
Guardian Address		
Closest Relative Name, Relationship, Address & Phone		
Client's Occupation and/or Source of Income		
Client's School/Grade;		
Client's Family Composition	Client's Living Arrangements	
Client's Medications (Previous)		
Client's Medications (Current)		
Client's 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	Client's 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 / CONSENT FOR TREATMENT		

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO HEALTH AFFILIATES MAINE FOR SERVICES NOT COVERED BY MY INSURANCE. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MISSED APPOINTMENTS IF I HAVE NOT NOTIFIED HEALTH AFFILIATES MAINE 24 HOURS IN ADVANCE. UNLESS I AM ALSO COVERED UNDER MAINECARE. I HEREBY AUTHORIZE HEALTH AFFILIATES MAINE TO FURNISH INFORMATION REGARDING MY DIAGNOSIS AND TREATMENT TO THE ABOVE INSURANCE CARRIERS AND/OR MAINECARE

I HEREBY AUTHORIZE PERMISSION FOR TREATMENT BY PROVIDERS OF HEALTH AFFILIATES MAINE.

Client/Guardian Signature: _____ **Date:** _____