

OASIS COUNSELING INTERNATIONAL FAMILY INFORMATION SHEET

HEAD OF HOUSEHOLD

Last Name _____
 First & Initial _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____
 Date of Birth ____/____/____ M/F
 Social Security Number _____
 Work # _____ Cell # _____

EMPLOYER

Address _____
 City _____ State _____ Zip _____
 Work Phone Number _____

INSURANCE #1

Company Name _____
 Address _____
 City _____ State _____ Zip _____
 Policy Holder _____
 Policy # _____
 Group # _____

INSURANCE #2

Company Name _____
 Address _____
 City _____ State _____ Zip _____
 Policy Holder _____
 Policy # _____
 Group # _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY: (Outside of Residence)

Name _____ Relationship _____ Phone Number _____
 Address _____ City _____ State _____ Zip _____
 Family Doctor Name: _____ Address: _____
 Phone Number: _____

REFERRED TO THIS OFFICE BY: _____

Please Check:

PAYMENT POLICY: I have read the payment policy printed on the back of this form and agree to its requests.

ASSIGNMENT AND RELEASE: I hereby authorize my **INSURANCE BENEFITS** to be paid directly to Oasis Counseling and understand that I am financially responsible for non-covered services as indicated on the back of this sheet. I also authorize Oasis Counseling to release any information necessary to process Insurance and Employee Assistance Claims. (A photocopy of this authorization will be considered valid.)

SIGNED _____

DATE ____/____/____ Read back page

SPOUSE

 Date of Birth ____/____/____ M/F
 Social Security Number _____
 Employer _____
 Address _____
 City _____ State _____ Zip _____
 Work # _____ Cell # _____

DEPENDENT'S NAME:

| | First | Last | M/F | Birth Date |
|----|-------|-------|-------|----------------|
| 1. | _____ | _____ | _____ | ____/____/____ |
| 2. | _____ | _____ | _____ | ____/____/____ |
| 3. | _____ | _____ | _____ | ____/____/____ |
| 4. | _____ | _____ | _____ | ____/____/____ |
| 5. | _____ | _____ | _____ | ____/____/____ |
| 6. | _____ | _____ | _____ | ____/____/____ |

DEPENDENT'S SOCIAL SECURITY

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____

PAYMENT POLICY

OASIS COUNSELING INTERNATIONAL

In order to provide the best possible service for our patients, we have recently revised our payment policy. Please take note of our current policy and plan accordingly for future visits.

FULL PAYMENT is expected at the time of service for all services unless one of the following exceptions applies:

1. You have private insurance and have met your deductible for the current year. If you have a co-pay, we ask that you pay your co-pay at the time of service.

NOTE: We will file your charges with your primary insurance company as a service to you. You will need to follow up with your insurance company in 2 to 3 weeks to make sure that the claim is received and is being processed. You will also need to make sure that you keep our office updated on any new insurance information to avoid denial of a claim.

2. Payment arrangements are made with our office **prior** to your visit with a medical provider.

NOTE: If your appointment is scheduled and you cannot pay for your visit at the time of service, please ask to visit with the front office prior to your visit in regards to making arrangements for a payment plan.

3. You are on **Medicaid** and have shown the receptionist your card for the current month.