

# Child & Adolescent Psychiatry Consulting LLC

## Behrend Psychology Consultants

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DBA

## Horses Treat

M407 Hwy 97, Marshfield, WI 54449  
715-318-0047 ; Fax: 888-485-4412  
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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Staus: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse Name (or parent, if child): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

IF PATIENT IS A CHILD: School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Responsible Party (will receive the statements)

Relationship to Client: Self Spouse Parent Other: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ State: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact you at home? Yes / No At work? Yes / No On Cell Phone? Yes / No

For a reminder call for my appts, please: Call Text Email I prefer not to have reminder calls \_\_\_\_\_

May we leave a message at home? Yes / No At work? Yes / No On Cell Phone? Yes / No

Insurance Information: Name & Address of Company \_\_\_\_\_

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security # \_\_\_\_\_

Medical Assistance # \_\_\_\_\_ County: \_\_\_\_\_

(Recent copy of MA card required)

**Authorization to pay benefits:** I hereby authorize payment directly to CAPC/BPC/HT from my insurance company for services performed at this clinic. I recognize and accept personal responsibility for the deductible amount and for any balance outstanding after payment of such insurance benefits. I authorize the release of any medical or other information necessary to process this claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If under 18-parent or guardian signature required)

I authorize CAPC/BPC/HT to release information concerning my treatment to the referring physician

Yes \_\_\_\_\_ No \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_