Green House Group, PA

CLIENT FIRST NAME _____ PRIMARY PHONE _____
Ok to leave message? Y N

CLIENT LAST NAME _____ SECONDARY PHONE _____
Ok to leave message? Y N

STREET ADDRESS _____ EMAIL _____
(Optional)

CITY, STATE, ZIP _____ DATE OF BIRTH _____
(Required)

Male_____ Female_____ Other_____ Married_____ Single_____ SOC SEC #_____-_____ -_____

PARENT NAME (if minor client)_____ PARENT PHONE _____
Ok to leave message? Y N

EMERGENCY CONTACT (name) _____ PHONE _____

IS CLIENT RESPONSIBLE FOR BILL? Y N If NO, list responsible party (parent or guardian) below:

RESPONSIBLE PARTY # 1 BILLING ADDRESS
(If different from above)

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

RESPONSIBLE FOR _____ % OF BILL

RESPONSIBLE PARTY # 2 BILLING ADDRESS

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

RESPONSIBLE FOR _____ % OF BILL

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME _____

I.D. # _____ POLICY # _____ GROUP # _____

CLIENT'S RELATION TO INSURED SELF_____ SPOUSE_____ CHILD_____ OTHER_____

POLICY HOLDER NAME _____ DATE OF BIRTH _____
(**Required**, if different from client)

ADDRESS _____ WORK TELEPHONE _____

CITY, STATE, ZIP _____ HOME TELEPHONE _____

EMPLOYER _____ SS # OF POLICY HOLDER _____

- I have been informed of HIPAA Privacy rules and how they relate to my services and care through GHG, PA: Y N
- I have submitted credit card information to GHG, PA for payment? Y N (Note: All credit account information is encrypted.)
  - If yes, I authorize all copays and coinsurances to be charged to the account provided? Y N

I understand that I am responsible for FULL payment for any balance related to services after my provider has fulfilled all contractual requirements with the insurer and exhausted all authorized benefits. I authorize payment of benefits by my insurer to Green House Group, PA for services described on the health insurance claim form. My signature below authorizes the release of any medical information necessary to the insurer of record to process insurance claims for services rendered.

_____ _____
Signature Date

If I choose to pay for services on my own and without insurance, I agree to pay $ _____ per session as discussed with my provider. If I choose not to use my insurance and pay privately for services, I agree to waive any right to reimbursement from my insurance company.

_____ _____
Signature Date

Effective 1/2021

Please fax to 603-668-8666 or email to: s.peoples@thegreenhousegroup.net