Beautiful Minds
MEDICAL, INC.

Patient's Information Sheet

Patient's Last's Name First Middle Initial	Date of Birth / /	Sex ☐ Male ☐ Female	Today's Date / /
Home Address City State Zip Code			Home Phone ( )
Mailing Address (if different from above) City State Zip Code			Cell Phone ( )
Marital Status (please check most recent) ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated	Social Security Number	Driver License Number State	
Employer's Name	Occupation		Employer's Phone Number ( )
Employer's Address City State Zip Code			
Last Name of Spouse, Parent or Legal Guardian First Middle Initial	Sex ☐ Male ☐ Female	Date of Birth / /	Preferred language
Home Address City State Zip Code	Preferred Pharmacy: City		Phone ( )
Primary Care Physician / City / Office Phone ( )	Referring Physician / City		Office Phone ( )

I heard about Beautiful Minds Medical from:

☐ Website /Facebook ☐ Referral (mark with an x) ____ Medical Professional ____ Friend/Relative ____ Other (specify) _____

CONSENT FOR TREATMENT, BILLING AND RELEASE OF MEDICAL INFORMATION

I understand I am responsible for all charges incurred for professional medical/mental health services provided for me or my dependent, regardless of insurance coverage. I authorize direct payment of any benefits to Beautiful Minds Medical, Inc. from my insurance company, health plan, third-party payor on any intermediaries.

I authorize Beautiful Minds Medical, Inc. and Daniel L. Binus, MD, to release medical records and/or information to representatives of my insurance company/ health plan/third-party payor or any intermediary for the purpose of processing my medical/mental health claims or obtaining benefits. In addition, I authorize Beautiful Minds Medical, Inc. and Daniel L. Binus, MD, Inc. to release medical information to other providers for the purpose of specialist referrals and/or other continuing care.

- ☐ **I consent to treatment by Beautiful Minds Medical, Inc. for counseling, psychotherapy and/or psychiatric medical care as deemed advisable and/or necessary by the professional staff of Beautiful Minds Medical, Inc.**
- ☐ **I also consent the release of my medication history from my insurance company or pharmacy benefits manager to Beautiful Minds Medical, Inc.**

For minor children patients:

- ☐ **I consent to emergency and/or routine counseling, psychotherapy and/or psychiatric medical care and treatment should my minor child present for treatment without a parent or legal guardian.**

_____ Date _____/_____/_____

Patient's, Parent or Guardian's Signature

INSURANCE INFORMATION

Subscriber's Last Name First Middle Initial	Subscriber's ID Number	Subscriber's Date of Birth / /
Primary Insurance Company's Name		Insurance Company Phone ( )
Coverage Effective Date: / / / Group Number:		Policy Number:
Secondary Insurance Subscriber's Name: if different from above	Subscriber's ID Number	Subscriber's Date of Birth / /
Secondary Insurance Company's Name		Secondary Insurance Company Phone ( )