Park Ridge Behavioral Healthcare, LLC

6500 E. 2ND ST SUITE 101
(307) 462-4876 (fax) 337-3492

Patient Name _____

Date of Birth_____ Gender _____ Age _____Marital Status_____

Mailing Address_____

City: _____ State___ Zip Code:_____S.S._____-_____-_____

Phone: (Hm)_____ (Cell)_____ (Cell2)_____

(Wk)_____ Email _____

I give my consent for PRBH to use phone, text, and email to remind me of my appointments. To confirm appointments please contact me on my (check all that apply):

Text ☐ Cell 1 ☐ Cell 2 ☐ Email ☐ Home ☐

School _____Grade_____

Physician _____ Referred By _____

Reason for Coming _____

Insurance Policy Holder/Responsible Payor _____

Address _____Date of Birth _____

Phone (Hm) _____ (Wk) _____Social Security ____-___-_____

Employed by _____Insurance Carrier_____

☐ **I am aware that I am responsible for payment at the time of service.** I hereby grant consent for Park Ridge Behavioral Healthcare (PRBH) to release my information to my insurance carrier for processing of insurance claims. I understand that some services may not be covered by my insurance plan, and I accept responsibility for all charges resulting from services provided by PRBH. I agree to pay all outstanding fees that remain due for more than 90 days, regardless of insurance coverage. I understand that unpaid balances may be accessed additional fees. I agree to pay all attorney and collection fees.

☐ I understand that charges will be made for missed appointments unless a 24-hour notice is given prior to the appointment time and date.

☐ I understand the PRBH providers may share protected health information with other PRBH providers to facilitate the provision of services.

☐ **I have read the Patient agreement and the Wyoming HIPPA Notice form and I agree to the terms and Conditions included in the forms. I give my consent for PRBH to provide mental health services based upon these terms and conditions.**

Patient or Guardian_____Date_____