Anne Arundel Medical Group - Mental Health Specialists

2635 Riva Road, Suite 108, Annapolis, Maryland 21401 Phone: (410) 573-9000 Fax: (410) 573-9001

Demographics

Last Name:	**First Name:**
Middle Name:	**Date of Birth: / / Sex: ❑M or ❑F**
Last 4 digits of Social Security No.:	**Marital Status:**
Address:	**City: State: Zip:**
Home Phone:	**Cell Phone:**
E-mail:	**Race & Ethnicity:**

Emergency Contact Information

Name:	**Phone:**

Employer Information

Name:	**Work Phone:**

Guarantor Information (to whom statements are sent) ❑ As above

Name:	**Phone:**
Address:	**City: State: Zip:**

Referring Provider / Facility (Required)	Primary Care Provider
Referring Provider: ❑Self Referral	**Primary Care Provider: ❑Same**

Primary Insurance Policy Holder ❑ As above

Last Name:	**First Name:**
Address:	**City: State: Zip:**
Last 4 digits of Social Security No.:	**Date of Birth: / / Sex: ❑M or ❑F**

How did you hear about us?

- ❑ Anne Arundel Medical Center / Ask AAMC
- ❑ AAMC Fast Care
- ❑ AAMC Kent Island Urgent Care
- ❑ Churches
- ❑ County Program - Specify:
- ❑ Day Care Center
- ❑ Employer
- ❑ Facebook / Social Media
- ❑ Former Patient
- ❑ Google / Internet search engine
- ❑ Epic In-Basket Message
- ❑ In-Store Advertising
- ❑ Insurance Company
- ❑ Magazine - Specify:
- ❑ Newspaper - Specify:
- ❑ Other - Specify:
- ❑ Primary Care Provider
- ❑ Physician Rating Website
- ❑ Practice Website
- ❑ Print Ads / Billboards
- ❑ Radio
- ❑ School
- ❑ Seminars
- ❑ Specialist Provider
- ❑ TV
- ❑ Word of Mouth

ASSIGNMENT AND RELEASE

- **I give my Permission and Consent for Treatment**
- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the provider, designated representative, or automated robot to contact me by telephone about appointments, billing, and medical care.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I acknowledge that I have been offered and viewed a copy of the "Notice of Privacy Practices" and the "Client Handbook"**
- **I understand a fee for missed appointments may apply (*see Client Handbook*).**

Signed:	**Date:**