Baxter Behavioral Health, LLC
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1130 Ten Rod Road, D101
North Kingstown, RI 02852

Client Registration

Patient Name: hkjkl _____
(first) *(middle)* *(last)*

DOB: ___/___/___ Sex *(circle one)*: Male Female

Address: _____ City/State/Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____)_____

Email: _____

Occupation/Employer: _____

COVID-19 Vaccination *(circle one)*: Yes No If yes, date of second vaccine: _____

Marital Statue *(circle one)*: Single Married Widowed Divorced

Parent/Guardian Name *(for minor clients)*: _____

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Subscriber Name & DOB: _____ Subscriber Phone: (____) _____

Subscriber Address: _____ Copay Amount: _____

Secondary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Subscriber Name & DOB: _____ Subscriber Phone: (____) _____

Subscriber Address: _____ Copay Amount: _____

I authorize the release of information necessary for the completion of any claim for insurance purposes. I further authorize appropriate medical payments to my provider. I acknowledge that I am responsible for such payments if not paid by my insurance carrier(s). Fees that are charged and not paid by the insurance company within 90 days are the responsibility of the client. I am aware that the use of cell phones does not guarantee confidentiality.

Signature: _____ Date: _____
(or signature of parent/guardian if under 18)