Be You Counseling Services, LLC
640 George Washington Highway, Building B, Suite 103 #19
Lincoln, RI 02865
401-580-8452

REGISTRATION FORM

(Please Print)

Today's date:	**PCP:**

PATIENT INFORMATION

Patient's last name: **First:** **Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid		
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:	**Social Security no.:**	**Home phone no.:** ( )			
P.O. box:	**City:**	**State:**	**ZIP Code:**		
Occupation:	**Employer:**	**Employer phone no.:** ( )			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance	❑ BC/BS of RI	❑ NHP	❑ Medicaid	❑ Tufts	❑
❑	❑	❑	❑ Welfare *(Please provide coupon)*	❑ Other	

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**	**Co-payment:** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*