Four County Mental Health Center
Established 1964

3751 W. Main, P.O. Box 688
Independence, KS 67301
(620) 331-1748
Fax (620) 332-1940

22214 D Street, Strother Field
Winfield, KS 67156
(620) 221-9664 or (620) 442-4540
Fax (620) 442-4559

1601 W. 4th
Coffeyville, KS 67337
(620) 251-8180
Fax (620) 251-7400

Emergency Services (800) 499-1748
www.fourcounty.com
Serving the Counties of Chautauqua, Cowley, Elk, Montgomery & Wilson

MRN: _____ **Date:** _____ **Time Arrived:** _____

THIS SECTION IS FOR PATIENT INFORMATION ONLY:

Full Legal Name: _____
Last First M.I. (Sr., Jr., II, etc.)

Have you previously received any other mental health services? □ No □ Yes Name of facility: _____

Gender: □ Male □ Female □ Transgender Male to Female □ Transgender Female to Male

Social Security #: _____ **Date of Birth:** _____

Marital Status: □ Never Married □ Married □ Divorced □ Separated □ Widow(er) □ Common Law

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Primary Phone:** _____ **Alt. Phone:** _____

Referred by: _____ **Highest Level of Education:** _____

Employer: _____ **Do you have current insurance?** □ No □ Yes: _____

Race/Ethnicity (mark all that apply):

□ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic/Latino
□ Native Hawaiian/Pacific Islander □ Caucasian □ Other/Unknown

How would you like to receive appointment reminders?: □ Phone □ Text □ Do not wish to receive reminder

Presenting Problem: _____

If client is a child, will anyone else be bringing him/her to Four County? (If yes, release of information needed):

_____ _____

STOP HERE! Reverse side will be completed by staff.

OFFICE USE ONLY (scan both sides of form)

MRN: _____ **Client Name:** _____

Emergency Contact	Financially Responsible Party
Primary Emergency Contact: _____ Phone #: _____ Relationship: _____ **Secondary** Emergency Contact: _____ Phone #: _____ Relationship: _____	Responsible Party for Payment: _____ Relationship to Patient: _____ Social Security #: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____ Employer: _____

Insurance Information	Secondary Insurance Information
Cardholder Name: _____ Relationship: _____ Employer: _____ Insurance: _____ Policy #: _____ Social Security #: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____	Cardholder Name: _____ Relationship: _____ Employer: _____ Insurance: _____ Policy #: _____ Social Security #: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

IMPORTANT – READ CAREFULLY

The patient or responsible party signing this form hereby certifies that the information on this form is complete and correct, and authorizes Four County Mental Health Center, Inc. to send information for billing as requested by payment sources. This information may include, if specifically requested, copies of the admission evaluation, treatment plans, discharge summary, clinical progress notes, and any other records produced by this agency. This authorization will expire upon completion of processing of my insurance claim and any subsequent requests or audits by the payment source, unless expressly revoked by me at an earlier date. I further understand that revoking my consent may result in my being responsible for payment of the claim and the above payment source(s) not being used.

If the information furnished above is not accurate or complete, Four County reserves the right to demand and receive its undiscounted fee. If insurance coverage is lost, patient will be responsible for payment. If delinquent, this account may be sent for collection and any unpaid portion may show up on your credit report. Four County reserves the right to charge an additional fee of 10% to recover a portion of the collection costs.

_____ _____ _____ _____

Signature - Financially Responsible Party Date **Staff Member Signature** Date

_____

Printed Name - Financially Responsible Party