Catholic Family Services

Basic Information and Agreement Sheet (BIAS)

IDENTIFIED PATIENT Date Of 1st Visit_____

Last Name_____First Name_____MI_____

Address_____City_____County_____State____Zip_____

Home#_____Work#_____Cell#_____Pager#_____

Message can be left at the following numbers (please check all that apply): _____Home _____Work _____Cell

SS#_____DOB_____Age____Gender____Race____Marital Status____Religion_____

Education_____Occupation_____Employer_____Veteran_____

How did you hear about us?_____If 18 years and up, do you have an Advance Directive? ____Yes ____No

Emergency Contact and Phone #_____

*Annual Household Income__$0-9,999__$10,000-$14,999__$15,000-$19,999__$20,000-$29,000__$30,000-$49,999__$50+__N/A
Number in Household_____ *This is compiled anonymously for the United Way and other funding sources.

NAME OF INSURED (if applicable) Relationship to Identified Patient_____

Last Name_____First Name_____MI_____

Address_____City_____County_____State____Zip_____

Home#_____Work#_____Cell#_____Pager#_____

SS#_____DOB_____Age____Gender____Race____Marital Status____Religion_____

Education_____Occupation_____Employer_____

Primary Insurance_____Member ID_____

Policy #_____Group #_____

Secondary Insurance_____Member ID_____

Policy #_____Group #_____

RESPONSIBLE PARTY FOR MINOR CHILD Relationship to Identified Patient_____

Last Name_____First Name_____MI_____

Address_____City_____County_____State____Zip_____

Home#_____Work#_____Cell#_____Pager#_____

SS#_____DOB_____Age____Gender____Race____Marital Status____Religion_____

Education_____Occupation_____Employer_____

YOUR FEE OR CO-PAYMENT AMOUNT $_____

YOUR DEDUCTIBLE AMOUNT $_____

PLEASE INITIAL AND SIGN BELOW:

_____ I certify that the above information is correct.
_____ I have received a copy of my Rights and Responsibilities.
_____ I agree to obtain the necessary authorizations to receive services.
_____ I agree to pay the fee, co-payment, and deductible and understand that payment is expected at the time services are rendered.
_____ I agree to pay the fee, co-payment, and insurance amount for non-emergency cancellations with less than a 24-hour notice.
_____ I give permission to Catholic Family Services to bill my insurance company and to receive payment for services.
_____ I understand that I remain personally responsible for payment of services provided.

Signature of Patient / Legal Guardian_____ Date_____

Signature of Staff Member_____ Date_____