Bright Harbor Healthcare
Building Better Tomorrows, One Life at a Time

CLIENT REGISTRATION INFORMATION / INSURANCE WAIVER

Today's Date _____ / _____ / _____ **Account #** _____

CLIENT INFORMATION

Last Name: _____ **First Name:** _____

Address: _____
(Street Address)

_____ _____ _____
(City) (State) (Zip)

Social Security Number: _____ - _____ - _____

Home Phone (_____) _____ - _____ **Business Phone** (_____) _____ - _____

Sex (Circle One) Male Female **Marital Status: Married Widowed Single**
(Circle One) Separated Divorced

Date of Birth: _____ /_____ / _____ **Race: Asian/Pacific Islander**
(Circle One) Black Hispanic White Other

BILLING INFORMATION
Responsible Party (if other than client)

Last Name: _____ **First Name:** _____

Address: _____
(Street Address)

_____ _____ _____
(City) (State) (Zip)

Social Security Number: _____ - _____ - _____

Home Phone (_____) _____ - _____ **Business Phone: (_____)** _____ - _____

Sex (Circle One) Male Female **Marital Status: Married Widowed Single**
(Circle One) Separated Divorced

Date of Birth: _____ /_____ / _____

Employer: _____ **Employer Phone: (_____)** _____ - _____

Employer Address: _____
(Street Address)

_____ _____ _____
(City) (State) (Zip)

INSURANCE INFORMATION:

Name of Insurance Company: _____

Policy: _____ **Group:** _____

Subscriber Information (If other than client)

Last Name: _____ **First Name:** _____

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____ /_____ / _____

I hereby authorize BRIGHT HARBOR HEALTHCARE to bill my insurance company for services rendered to me and / or my family members. I also authorize the agency to released any and all appropriate information required by said companies for the payment of any claims submitted by BRIGHT HARBOR HEALTHCARE. I am aware that filing insurance claims is not a guarantee of payment. If my insurance company does not make payment on claims for services rendered by BRIGHT HARBOR HEALTHCARE or if services are denied for any reason, I understand that I will be responsible for my assigned fee.

X _____
Signature of client, parent or guardian Date

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(*use "✓"to indicate your answer*)

	Not at all	Several Days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)	**TOTAL**			

10. If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or getting along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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