Birgit Amann, M.D., PLLC
Diplomate: American Board of Psychiatry and Neurology
Board Certified – Child, Adolescent and Adult Psychiatry

Barika Butler, M.D.
Diplomate: American Board of Psychiatry and Neurology
Board Eligible – Child, Adolescent and Adult Psychiatry

1639 E. Big Beaver Road Suite 201 | Troy, MI 48083 | Ph.:248-528-9000 | Fax.:248-528-9005

PATIENT INFORMATION

PLEASE PRINT CLEARLY (last name, first name)

TODAY'S DATE: ______________________

PATIENT NAME________________	RESPONSIBLE PARTY'S NAME________________
ADDRESS________________	ADDRESS________________
CITY__________STATE______ZIP______	CITY__________STATE______ZIP______
SOCIAL SECURITY #________________	SOCIAL SECURITY #________________
BIRTH DATE__________AGE______SEX______	BIRTH DATE__________AGE______SEX______
MARITAL STATUS________________	MARITAL STATUS________________
HOME PHONE________________	HOME PHONE________________
CELL PHONE________________	CELL PHONE________________

EMPLOYER INFORMATION (PATIENT AND/OR RESPONSIBLE PARTY)

PATIENT'S EMPLOYER________________	RESPONSIBLE PARTY/INSURED'S EMPLOYER________________
ADDRESS________________	ADDRESS________________
CITY__________STATE______ZIP______	CITY__________STATE______ZIP______
WORK PHONE________________	WORK PHONE________________
HOURLY ☐ SALARIED ☐ RETIRED ☐	HOURLY ☐ SALARIED ☐ RETIRED ☐

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME________________	PHONE__________RELATIONSHIP __________
ADDRESS________________	CITY__________STATE______ZIP______

REFERRAL INFORMATION

REFERRAL INFORMATION: MAY WE RELEASE THIS INFORMATION TO YOUR REFERRAL SOURCE? YES ☐ NO ☐

NAME OF REFERRING PARTY________________	FACILITY________________
ADDRESS________________	CITY__________STATE______ZIP______

RELEASE OF INFORMATION

I HERBY AUTHORIZE BEHAVIORAL MEDICAL CENTER TO RELEASE INFORMATION REGARDING MY CASE TO MY INSURANCE COMPANY AND TO ANY OTHER REFERRING COLLEAGUE AT BEHAVIORAL MEDICAL CENTER.

SIGNATURE________________ RELATIONSHIP________________DATE__________

PAYMENT RESPONSIBILITIES

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF ANY INSURANCE POLICY(IES). I AGREE TO PAY IN FULL ANY AND ALL DEBTS THAT I MAY INCUR IN THE COURSE OF TREATMENT FOR EITHER MYSELF OR AS A GUARANTOR. I FURTHER UNDERSTAND THAT ALL FEES ARE PAYABLE AT THE TIME OF SERVICE.

SIGNATURE________________ RELATIONSHIP________________DATE__________

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