SAINT LOUIS COUNSELING

Basic Information and Agreement Sheet (BIAS)

IDENTIFIED PATIENT

Last Name_____ First Name_____ MI_____

Address_____ City_____ County_____ State_____ Zip_____

Home#*_____ Work#_____ Cell#_____ Email_____

Messages can be left at the following *(please check all that apply)*: ☐ Home* ☐ Work ☐ Cell ☐ Email

**Please note automated reminder calls/messages will be made to the listed Home#.*

SS#_____ DOB_____ Age_____ Education Level/ Grade Level _____

Occupation_____ Employer_____

Emergency Contact and Phone #_____ Email_____

Gender:
- ☐ Female
- ☐ Male
- ☐ Other_____
- ☐ Prefer Not to Answer

Race:
- ☐ African American
- ☐ Asian
- ☐ Bi/Multi Racial
- ☐ Hawaiian/Pacific Islander
- ☐ Hispanic/Latino
- ☐ Native American/ Alaskan Native
- ☐ White
- ☐ Other: _____
- ☐ Prefer Not to Answer

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Widow
- ☐ Separated
- ☐ Divorced
- ☐ Domestic Partnership
- ☐ Common Law
- ☐ Other _____
- ☐ Prefer Not to Answer

How did you hear about us?:
- ☐ Radio
- ☐ Print
- ☐ Social Media
- ☐ Other Online
- ☐ Doctor
- ☐ Hospital
- ☐ Friend
- ☐ Family
- ☐ School
- ☐ Other _____
- ☐ Prefer not to answer

Religion:
- ☐ Catholic
- ☐ Christian
- ☐ Jewish
- ☐ Muslim
- ☐ Buddhist
- ☐ Nonreligious
- ☐ Other _____
- ☐ Prefer not to answer

Annual Household Income:
- ☐ $0-9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$29,000
- ☐ $30,000-$49,999
- ☐ $50,000-$100,000
- ☐ $100,000+
- ☐ Prefer not to answer

Number in Household:
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8 or more

Veteran:
- ☐ Yes
- ☐ No
- ☐ Current Military
- ☐ Other _____
- ☐ Prefer not to answer

NAME OF INSURED (If different from above)

Relationship to Identified Patient_____

Last Name_____ First Name_____ MI_____

Address_____ City_____ County_____ State_____ Zip_____

Home#_____ Work#_____ Cell#_____ Email_____

SS#_____ DOB_____ Age_____

INSURANCE INFORMATION (If applicable)

Primary Insurance_____ Member ID_____

Policy #_____ Group #_____

Secondary Insurance_____ Member ID_____

Policy #_____ Group #_____

EAP INFORMATION (Please complete only if using an EAP provider plan rather than insurance)

EAP Company _____ EAP Company Phone # _____

Authorization # _____ Number of visits approved _____ Expiration Date for visits _____

RESPONSIBLE PARTY FOR MINOR CHILD Relationship to Identified Patient_____

Last Name_____First Name_____MI_____

Address_____City_____County_____State_____Zip_____

Home#_____Work#_____Cell#_____Email_____

SS#_____ DOB_____ Age_____ Gender_____

Education_____Occupation_____Employer_____

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. (GRANT/ EAP EXEMPT)
_____ I agree to pay the fee, co-payment, and insurance amount for non-emergency cancellations with less than a 24-hour notice. (GRANT/ EAP EXEMPT)
_____ I give permission to Saint Louis Counseling 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 Therapist_____ Date_____

OFFICE USE ONLY

DATE OF 1ST VISIT_____

Client has/is using: ☐ Insurance ☐ Arch EAP ☐ Other EAP ☐ Sliding Scale

☐ Grant: _____ ☐ Project Rachel ☐ Project Joseph

FEE OR CO-PAYMENT AMOUNT $_____

DEDUCTIBLE AMOUNT $_____

Signature of Staff Member_____ Date_____