

## Basic Information and Agreement Sheet (BIAS)

<u>IDENTIFI</u>	ED PATIENT									
Last Nam	ne	First Name					_ MI			
Address_				_City	County		State_	Zip_		
Home#*_		Work	#	Cell#_			Email			
Message	s can be left at the follow	wing <i>(plea</i>	ase check all that app	<i>ly)</i> :H	ome*\	Work	Се	ell	Email	
SS#	automated reminder calls/messa	3	Age Ed	ducation Lev	vel/ Grade Level _					
Occupation	on			Employer						
Occupation Employer Emergency Contact and Phone # Email										
Gender	:	Race:		Marital	Status:		How did y	ou hear	about us?:	
	Female		African American		Single			adio		
	Male		Asian		Married			rint		
	Other		Bi/Multi Racial		Widow			ocial Me		
	Prefer Not to Answer		Hawaiian/Pacific		Separated			ther Onli	ne	
			Islander		Divorced			octor		
			Hispanic/Latino		Domestic Partne	ership		lospital		
			Native American/ Alaskan Native		Common Law			riend		
			White		Other			amily		
			Other:		Prefer Not to Ans	swer		chool		
			Prefer Not to Answer					)ther		
Religion	n·	Annua	I Household Income:	Numbe	r in Household:		☐ P Veteran:	reter not	to answer	
	Catholic		\$0-9,999		1			es		
	Christian		\$10,000-\$14,999		2			lo		
	Jewish		\$15,000-\$19,999		3			urrent Mi	litary	
	Muslim		\$20,000-\$29,000		4			ther	•	
	Buddhist		\$30,000-\$49,999		5				to answer	
	Nonreligious		\$50,000-\$100,000		6					
	Other		\$100,000+		7					
	Prefer not to answer		Prefer not to answer		8 or more					
NAME O	F INSURED (If differer	nt from a	above)	Relationsh	ip to Identified Pat	tient				
Last Name				First Name					MI	
Address_				_City	County		State_	Zip_		
				-	_			-		
	DOE									
	NCE INFORMATION (If		•							
Primary I	nsurance				Member I	D				
Primary Insurance Policy #				Group #						
Secondary InsuranceMember 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 PA	ARTY FOR MINOR CHIL	<u>D</u>	Relationship to Identified Patient								
Last Name			First Name_		MI						
Address			City	County	State	Zip					
Home#	Work#		Cell#		Email						
SS#	DOB	Age	Gender								
Education	Occu	pation		Employer							
PLEASE INITIAL AND SIGN BELOW:											
<ul> <li>I have received a copy of my Rights and Responsibilities.</li> <li>I agree to obtain the necessary authorizations to receive services.</li> <li>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)</li> <li>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)</li> <li>I give permission to Saint Louis Counseling to bill my insurance company and to receive payment for services.</li> <li>I understand that I remain personally responsible for payment of services provided.</li> </ul>											
Signature of Pati	ient / Legal Guardian			Date							
Signature of The	rapist		Date								
		<u>OFI</u>	FICE USE ONL'	<u> </u>							
DATE OF 1ST VISIT	Г										
Client has/is using	g: Insurance	Arch EAP	Other EAI	Sliding S	Scale						
	Grant:		Project Ra	chel Project J	loseph						
FEE OR CO-PAYMENT AMOUNT \$											
DEDUCTIBLE AMOUNT \$											
Signature of Stat	ff Member			Date							

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