CORSICA RIVER MENTAL HEALTH SERVICES, INC.

120 BANJO LANE
CENTREVILLE, MD 21617
Phone (410) 758-2211
Fax (410) 758-0698

403 HIGH STREET
CAMBRIDGE, MD 21613
Phone (443) 225-5780
Fax (443) 225-5783

332 N. MAIN STREET
FEDERALSBURG, MD 21632
Phone (410) 479-0511
Fax (410) 754-6080

Thank you for your interest in Corsica River Mental Health Services, Inc. The enclosed packet contains the items you will need to complete prior to becoming enrolled for services. Along with the enclosed packet of information, we also need you to provide the following documentation:

- ☐ All current Insurance Cards - primary and secondary*
- ☐ Photo ID
- ☐ Patient Social Security Card
- ☐ Primary Medical Doctors name, address and phone number
- ☐ List of all Medications

Only if Minor:

- ☐ Proof of custody (Custody order), if applicable
- ☐ Immunization record
- ☐ Birth Certificate

It is requested you bring the following, if applicable:

- ☐ Reports from previous psychological evaluations/testing
- ☐ Copies of child's Individualized Education Plan (IEP)

* If you/your child currently has no insurance, please bring in the following for income verification:

- ☐ 3 most current pay stubs

OR

- ☐ Prior Year tax return

Acceptance and scheduling for an Intake is dependent on qualifying for services and, if required, obtaining authorizations for services

**** Please be advised: For private insurance carriers, the registration process may take up to 7 business days. In order for this process to begin, the <u>Registration</u> process must be completed – Thank you!

PLEASE NOTE: Failure to provide all necessary documents may delay scheduled clinical visits

CORSICA RIVER
Providing Behavioral Health Services on the Mid-Shore

120 BANJO LANE
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Client Registration Form

PLEASE PRINT CLEARLY

Date: ____________

Client Information

Client's Name: ____________ Preferred Name (nickname) ____________

Address: ____________

City: ____________ State: ______ Zip: ______ Email: ____________

Phone#: (home) ____________ (work) ____________ (cell) ____________

Social Security #: ____________ Date of Birth: ____________ Age: ______

Race: ____________ Marital Status: ____________

Gender: ______ Male ______ Female ______ Male to Female ______ Female to Male

Preferred Method of Communication (please check one and complete)

_____Email (please provide if different than above) ____________

_____Phone (please designate number) ____________

_____Text (please designate number) ____________

Employed: _____ Full Time _____ Part Time _____ Not Employed

Are you a Veteran? _____ Yes _____ No

Employer: ____________

Address: ____________ Phone: ____________

Primary Insurance Information

Company Name ____________

Member ID No. ____________ Group No. ____________

Name of Insured ____________

Address if different from above ____________

____

Insured's Phone (home) ____________

(work) ____________ (cell) ____________

Birth Date ____________ Social Security ____________

Insured's Employer ____________

Secondary Insurance Information

Company Name ____________

Member ID No. ____________ Group No. ____________

Name of Insured ____________

Address if different from above ____________

____

Insured's Phone (home) ____________

(work) ____________ (cell) ____________

Birth Date ____________ Social Security ____________

Insured's Employer ____________

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Client Name ____________

Primary Emergency Contact

Name: ______________________ Address: ______________________

Phone #: (home/cell) ______________ (work) __________ Relationship: __________

Two Additional Emergency Contacts (<u>*required if the client is a minor*</u>)

Name: ______________________ Address: ______________________

Phone #: (home/cell) ______________ (work) __________ Relationship: __________

Name: ______________________ Address: ______________________

Phone #: (home/cell) ______________ (work) __________ Relationship: __________

Referral Information

Are you related to, or in a relationship with an employee of Corsica River Mental Health Services or Crossroads Community, Inc.? _____Yes _____No (If Yes, please list their name and relationship)

Name ______________________ Relationship ______________________

What brings you in? ______________________

____

Referred by? _____Self_____ Doctor _____ Family Member _____ Probation Officer_____ Legal/Court Issues _____*Other

*(Other – please explain) ______________________

Please specify which therapy you are interested in?

(check all that apply): _____Individual ____ Family ____ Couples _____ Substance Use _____School-Based

Previous Psychological Testing? Y/N ______ (*please bring copies to your first appointment*)

Primary Care Physician: ______________________ Phone#: ______________

Address: ______________________

Date last seen: __________ Allergies (all types): ______________________

Current Medications: ______________________

____

Significant Medical History (include developmental difficulties, allergies, surgeries, illnesses, etc. with approximate dates):

____

____

____

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