Beautiful Minds Medical, Inc.
Daniel L. Binus, MD

PATIENT INFORMATION SHEET

Patient's Last's Name First Middle Initial	Date of Birth / /	Sex ☐ Male ☐ Female	Today's Date / /
Home Address City State Zip Code			Home Phone ( )
Mailing Address: if different from above City State Zip Code			Cell Phone ( )

Marital Status ☐ Legally Separated ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Social Security Number - -	Driver License Number State	Email Address

Employer's Name	Occupation	Employer's Phone Number ( )
Employer's Address City State Zip Code		

Last Name of Spouse, Parent or Legal Guardian First Middle Initial	Sex ☐ Male ☐ Female	Date of Birth / /
Home Address City State Zip Code		Home Phone ( )

Social Security Number - -	Driver License Number State	Preferred Language

Employer's Name	Work phone number ( )	Referring Physician/City	Office Phone ( )
Preferred Pharmacy/ City Phone		Primary Care Physician/City	Office Phone ( )

I heard about Beautiful Minds Medical from:

☐ Word of Mouth ☐ Referral from my Physician or other MH professional: ☐ Internet ☐ Other:

CONSENT FOR TREATMENT, BILLING AND RELEASE OF MEDICAL INFORMATION

I understand I am responsible for all charges incurred for professional medical/mental health services provided for me or my dependent, regardless of insurance coverage. I authorize direct payment of any benefits to Beautiful Minds Medical, Inc. from my insurance company, health plan, third-party payor on any intermediaries.

I authorize Beautiful Minds Medical, Inc. and Daniel L. Binus, MD, to release medical records and/or information to representatives of my insurance company/ health plan/third-party payor or any intermediary for the purpose of processing my medical/mental health claims or obtaining benefits. In addition, I authorize Beautiful Minds Medical, Inc. and Daniel L. Binus, MD, Inc. to release medical information to other providers for the purpose of specialist referrals and/or other continuing care.

☐ I consent to treatment by Beautiful Minds Medical, Inc. for counseling, psychotherapy and/or psychiatric medical care as deemed advisable and/or necessary by the professional staff of Beautiful Minds Medical, Inc. ☐ I also consent the release of my medication history from my insurance company or pharmacy benefits manager to Beautiful Minds Medical, Inc.

For minor children patients:
☐ I consent to emergency and/or routine counseling, psychotherapy and/or psychiatric medical care and treatment should my minor child present for treatment without a parent or legal guardian.

_____ Date _____/_____/_____
Patient's, Parent or Guardian's Signature

INSURANCE INFORMATION

Subscriber's Last Name First Middle Initial	Subscriber's ID Number	Subscriber's Date of Birth / /
Primary Insurance Company's Name		Insurance Company Phone ( )

Coverage Effective Date: / /	Group Number:	Policy Number:
Secondary Insurance Subscriber's Name: if different from above	Subscriber's ID Number	Subscriber's Date of Birth / /
Secondary Insurance Company's Name		Secondary Insurance Company Phone ( )
Coverage Effective Date: / /	Group Number:	Policy Number: