Genesis Behavioral Health Services
433 Metairie Rd, Suite 520, Metairie, LA 70005

PATIENT INFORMATION UPDATE FORM

PATIENT INFORMATION

Patient's Name: _____ Pronouns: _____
Last First

Home Address: _____
City State ZIP

Date of Birth: ____/____/_____ Age: _____ Gender: _____

Email: _____ Phone Number: (_____)_____-_____

Marital Status: Married Single

EMERGENCY CONTACT

Contact Name: _____
Last First

Relation: _____ Phone Number: (_____)_____-_____

Home Address: _____
City State ZIP

INSURANCE

We are required to submit your insurance information when obtaining prior authorization for prescriptions. Please attach a copy of the insurance card, front and back, and driver's license.

Insurance Company: _____ Phone Number: (_____)_____-_____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder DOB: ____/____/_____
Last First

Employer of Policy Holder: _____

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CREDIT CARD INFORMATION

The card will be charged in accordance with our office and cancellation policies.

Name as is appears on the card: _____ Phone: (____)_____-_____

Type of Card: ❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS

Credit Card Number: _____ Expiration Date: ____/_____

Security Code BACK of Visa OR Master Card (3 digits): _____

Security Code FRONT of Amex Card (4 digits): _____

Billing Address: _____
City State ZIP

****I hereby authorize this card to be used for payment of services rendered and future services rendered.**

_____ _____
Patient Signature (or Parent/Guardian if Patient is a minor) Date

☐ **Client provides consent via virtual signature.**

*****If using Adobe to submit this form, simply click Submit Form and send using your default email application or webmail preference. If not using Adobe to submit this form, please save the completed form, attach it to a new email, and send to charlottel@beaconbh.com. After either option, please check you sent email folder to confirm it has been sent.***