*All information is confidential and protected under HIPAA. Fields marked with * are required. Contact us at support@backcountrymentalhealth.com if you nee assistance.*

1 PATIENT DEMOGRAPHICS

*Legal Last Name | *Legal First Name | Middle Initial | Suffix (Jr./Sr./III) | Preferred Name / Nickname

*Date of Birth (MM/DD/YYYY) | *Age | *Legal Sex at Birth (M / F / X) | Gender Identity | Pronouns (she/her, he/him, they/them…)

Race / Ethnicity (optional) | Primary Language | Interpreter Needed? Y / N | SSN Last 4 Digits

2 CONTACT INFORMATION

*Street Address (include Apt / Unit #)

*City | *State | *ZIP | County

*Primary Phone | Type Cell / Home / Work | May We Leave a Voicemail? Y / N | May We Text? Y / N

Secondary Phone (optional) | Type | *Email Address

Preferred contact method:

- ☐ Phone call
- ☐ Text message (standard messaging rates may apply)
- ☐ Email
- ☐ Secure patient portal message

3 EMERGENCY CONTACT

*Emergency Contact – Full Name | *Relationship | *Phone (Primary) | Phone (Secondary)

May we contact this person without your explicit permission if we are concerned for your safety?

- ☐ Yes — I authorize contact in a safety emergency
- ☐ No — discuss with me first (except immediate life-threatening emergencies)

Additional Emergency Contact – Full Name | Relationship | Phone

4 PRIMARY CARE & REFERRING PROVIDER

Primary Care Provider (PCP) Name | Practice / Clinic | PCP Phone

May we coordinate care with your PCP (send/receive notes and records)?

- ☐ Yes
- ☐ No

Referring Provider (if applicable) | Specialty | Phone / Fax

How did you hear about our practice?

- ☐ Referral from PCP or specialist
- ☐ Insurance directory (e.g., Optum, Premera, Regence)
- ☐ Online directory (Psychology Today, Headway, TherapyDen)
- ☐ Internet search
- ☐ Friend or family recommendation

Other:

5 PRIMARY INSURANCE

Insurance Company Name

Plan Name / Type (PPO, HMO, Medicaid)

Member ID #

Group #

Insurance Phone (on card)

Is the policyholder the patient?

- [ ] Yes
- [ ] No — complete below:

Policyholder Full Name

Policyholder DOB

Relationship to Patient

6 SECONDARY INSURANCE (IF APPLICABLE)

Insurance Company Name

Plan Name / Type

Member ID #

Group #

Insurance Phone

Policyholder Full Name (if different)

Policyholder DOB

Relationship to Patient

7 PREFERRED PHARMACY

Pharmacy Name

City

Phone

8 CERTIFICATION & SIGNATURE

I certify that the information provided on this registration form is true, accurate, and complete to the best of my knowledge. I agree to notify this practice promptly of any changes. I understand that this practice may verify my insurance benefits and that I am responsible for any amounts not covered by my insurance.

Patient / Guardian Signature

Printed Name

Date

If signed by a parent, guardian, or legal representative:

Relationship to Patient

Legal Authority (Parent / Legal Guardian / POA)