BEHAVIORAL HEALTH SYSTEMS

ADDITIONAL CLINICAL NOTES *(OPTIONAL FORM)*

Patient Name: _____ Date of Birth: _____-_____-_____ Today's Date _____

Insured Employer: _____ Provider Name, Licensure:_____

These notes pertain to the following date of service:_____

Two Metroplex Drive • Suite 500 • Birmingham, AL 35209 • (800) 245-1150 • Fax (205) 879-1178 • www.behavioralhealthsystems.com