

INTAKE

Date: _____ Time: _____
 Referred By: _____
 Name: _____ DOB: _____
 Home Phone: _____ IP Cell Ph: _____ email: _____
 Parents Name: _____
 Mother's Cell Ph: _____ Mother's Work Ph: _____
 Father's Cell Ph: _____ Father's Work Ph: _____
 Spouse Name: _____
 Spouse Cell Ph: _____ Spouse Work Ph: _____
 Address: _____ City _____ Zip _____

Please describe what precipitated your call for help:

Modality: Individual Marital Family Group Parenting Class

BENEFITS/INSURANCE INFORMATION

Insured's Name: _____
 Insured's DOB: _____ Insured SS#: _____
 Insured's Employer _____
 ID# _____ Group# _____
 Benefit Info received from: _____ Ph # _____
 Is PCP Referral Necessary?: _____
 Insurance Co. Name _____ Mental Health Managed by _____
 Insurance Ph. _____

For Billing Administrator only

Effective Date of Policy: _____ Max # sessions/yr _____ Percent Cov _____ %
 Deductible Amount: _____ Has Deductible Been Met? _____
 CoPay: _____ CoInsurance: _____ %
 Claims Sent to: _____
 Date of First Session: _____
 Authorization #: _____
 Certified By: _____
 # of Sessions Authorized: _____
 Is TRF/Authorization Necessary?: _____

Notes: