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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFERRAL SOURCE** | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **REFERRAL PHONE #** | | | | | | | |  | | | | | | | | | | **DATE** | | |  | | | | | | |
| **INTAKE REP** | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **CLIENT INFORMATION** (as it appears on Insurance Card) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NAME** | |  | | | | | | | | | **DOB** | | |  | | | | | **MALE** | | |  | | | **FEMALE** | |  |
| **STREET ADDRESS** | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **CITY** | |  | | | | | | | | | | **STATE** | | | | |  | | | | **ZIP** | | |  | | | |
| **CONTACT PHONE** | | | | |  | | | | | | **COMMUNITY** | | | | | | |  | | | | | | | | | |
| **ALTERNATE PHONE** | | | | | | | |  | | | | **EMAIL** | | | |  | | | | | | | | | | | |
| **TO BE SEEN AT** | | |  | | | | **HOME** | |  | **OFFICE** | | | **CLIENT KNOWS ABOUT REFERRAL? Yes or No** | | | | | | | | | | | | |  | |
| **SHOULD POA/FAMILY BE CALLED FIRST? Yes or No**  **(If Yes, fill out information below)** | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **NAME** |  | | | | | | | | **RELATIONSHIP** | | | | |  | | | | | | **PHONE** | | |  | | | | |
| **REFERRAL REASON** | | | | | | | | | Notes:  Ins Verification: In Network Mental Health Benefits  Ded. Total:$ Ded. Met so far:$  Copay$ or Co Ins: Patient: % Ins: %  CPT Codes Not-Covered:  Out of Network Mental Health Benefits  Ded. Total:$ Ded. Met so far:$  Copay$ or Co Ins: Patient: % Ins: %  CPT Codes Not-Covered:  Rep. Name: Ref. #  Verified by: | | | | | | | | | | | | | | | | | | |

*Attach a copy of insurance cards (front and back) that will be billed for services.*

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| **INSURANCE INFORMATION** | | | | | |
| **SOCIAL SECURITY NUMBER** | |  | | | |
| **PRIMARY** |  | | **INSURANCE PHONE #** |  | |
| **POLICY #** |  | | **GROUP #** |  | |
| **SECONDARY** |  | | **INSURANCE PHONE** |  | |
| **POLICY #** |  | | **GROUP #** |  | |
| **DOES CLIENT OR RESPONSIBLE PARTY ACCEPT UP TO A $20 CO-PAY?**  **(Yes or No)** | | | | |  |

Billing Address (If different from Client Address above.)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME** |  | | | | | |
| **STREET ADDRESS** | |  | | | | |
| **CITY** |  | | **STATE** |  | **ZIP** |  |