|  |  |
| --- | --- |
| **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 BenefitsDed. Total:$ Ded. Met so far:$Copay$ or Co Ins: Patient: % Ins: %CPT Codes Not-Covered: Out of Network Mental Health BenefitsDed. 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** |  |