PATIENT INTAKE FORM

Clinician:_____ **Intake Date:**_____

PATIENT INFORMATION

Name: (First)_____ **MI:**_____ **Last:**_____**Home phone:**_____

Address:_____ **Cell phone:**_____

City, State, Zip:_____ **Employer:**_____ **DOB:**_____

Sex: _____male _____female SS # or Driver's Lic:_____ **Referral Source:**_____

Person to Notify in Case of Emergency:

Name:_____ **Relationship:**_____ **phone # (H)**_____

Address:_____**City, State, Zip:**_____ **(W)**_____

Responsible Party: (if other than patient) Name:_____ DOB: _____

SS # or Driver's Lic #:_____**Relationship:**_____ **phone (H):**_____

Address (if other than above):_____**(W):**_____

Insurance Information:

PRIMARY INS. CO. NAME_____ **ID #:**_____

Mental Health Benefits Phone #:_____ **Auth Obtained:_____yes _____no**

Mental Health Claims Address:_____ **Authorization #:**_____

City, State, Zip:_____ **# of visits allowed:**_____

Policyholder name/DOB:_____ **date range of auth:**_____

Policyholder's relationship to patient:_____self _____spouse _____ parent _____other

Policy/Group #:_____**policyholder's employer name:**_____**copay amt: $**_____

SECONDARY INS. CO. NAME_____**ID#:**_____

Claims Address:_____**City, State, Zip:**_____

Subscribers name:_____**Relationship to pt:**_____ **Policy Group #:**_____

Authorization info. if required for secondary:_____

General Information

Patient's Marital Status (circle one): Single Married Other

I request payment of authorized insurance benefits be made on my behalf to Psychological Associates for any services furnished to me. I hereby authorize my clinician at Psychological Associates (PASM) to administer such treatment as may be deemed necessary or advisable, and to provide such information to the above named insurance or managed care company as may be required by them to process payment of claims on authorized visits.

I have received from and discussed with my clinician a copy of the following Psychological Associates forms: 1. Office Policies and Procedures, 2. Privacy Practices, and 3. Cancellation and Missed Appointment Policy, and I understand how/what I may be charged. I also understand that I am ultimately responsible for my bill.

Signature of Patient or Responsible Party:_____**Date:**_____

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