# Intake Sheet

**Therapist Name:**
**Date & Time of Appt:**

**Instructions:**
Please Complete Red Fields Only and Sign/Date

**Contact:**
**Relationship to Patient:**

**TODAY'S DATE:**

| | | | | | |
|---|---|---|---|---|---|
| **PATIENT NAME: First** | **Middle** | **Last** | **AGE:** | **DATE OF BIRTH:** | **SEX:** |
| **HOME ADDRESS: Street** | | | **City** | **State** | **Zip** |
| **HOME TELEPHONE:** | **WORK TELEPHONE:** | | | **CELL PHONE NUMBER:** | |
| **PRIMARY INSURANCE: Co. Name** | **Insurance ID #** | | **Pt SS #** | **Insurance Group #** | **Marital Status** |
| **Insured's Name** | **Address** | | | **Insured's SS #** | **Insurance Phone #** |
| **Insured's DOB** | **Sex** | **Employer's Name** | | **Is there another health benefit plan?** | |
| **REFERRAL SOURCE:** | **REASON FOR THERAPY:** | | | | **EAP:** |

| | | |
|---|---|---|
| **Deductible: 0**<br><br>Tricare Pcp name:<br>Phone #:<br>Upin#:<br>**Amount Met: $_______** | **Co-Pay:**<br>**PHD**: 90801- / 90806,46 & 47- / 90853- / 96100-<br>**LCSW**: 90801- / 90806,46 & 47- / 90853-<br>BIOBASE BENEFIT: | **Visits Allowed:**<br>Calendar or Contract Year: _______<br><br>Do you cover LPC's/LCSW's & LCNS's? Yes / No |
| **Insurance:**<br><br>Spoke with: | **Insurance Phone #:**<br><br>Policy Effective Date: | **Is Preauth Required? Yes / No**<br>**Pt calls for the authoriz? Yes / No**<br>Auth #:<br># of Sessions:<br>Start & End Date: |
| **Claim Payor Name:** | **Referral from Psych: Yes / No**<br>Opt Choice, MDIPA, Mamsi , Alliance CTP in or CTP NOT in schedule 1-2 wks out. | **Is psych test a benefit? Yes / No**<br>How many hrs allowed per year?<br>Is a form needed? Yes / No<br>Fax# |

* **Insurance co-payments are due at the time of service. Due to rising cost of mailing statements, if co-payment is not paid at the time of service, there will be a $5.00 fee charged to your account.**

**Cancellation Policy**

A 24-hour notice is required for cancellation of your scheduled appt. A missed appt. fee will be charged.

**Certification and Authorization**

**I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Prince William Family Counseling, P.C. on my behalf. Therefore my signature will be on file to file with my insurance company.**

**Members of Optimum Choice, MDIPA, Mamsi & Alliance**

**I acknowledge that I am responsible for having my Consultant Treatment Plan (CTP) at the time of service. If I fail to have the CTP than I am responsible for the fee that is not covered by my insurance company.**

**Signature of Patient (or Parent):** ______________________________ **Date:** ____________