

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 Tricare Pcp name: Phone #: Upin#: Amount Met: \$_____	Co-Pay: <table style="width: 100%; border: none;"> <tr> <td style="border: none;">PHD</td> <td style="border: none;">LCSW</td> </tr> <tr> <td style="border: none;">90801-</td> <td style="border: none;">90801-</td> </tr> <tr> <td style="border: none;">90806,46 & 47-</td> <td style="border: none;">90806,46 & 47-</td> </tr> <tr> <td style="border: none;">90853-</td> <td style="border: none;">90853-</td> </tr> <tr> <td style="border: none;">96100-</td> <td style="border: none;"></td> </tr> <tr> <td colspan="2" style="border: none;">BIOBASE BENEFIT:</td> </tr> </table>	PHD	LCSW	90801-	90801-	90806,46 & 47-	90806,46 & 47-	90853-	90853-	96100-		BIOBASE BENEFIT:		Visits Allowed: Calendar or Contract Year: _____ Do you cover LPC's/LCSW's & LCNS's? Yes / No
PHD	LCSW													
90801-	90801-													
90806,46 & 47-	90806,46 & 47-													
90853-	90853-													
96100-														
BIOBASE BENEFIT:														
Insurance:	Insurance Phone #:	Is Preauth Required? Yes / No Pt calls for the authoriz? Yes / No												
Spoke with:	Policy Effective Date:	Auth #: # of Sessions: Start & End Date:												
Claim Payor Name:	Referral from Psych: Yes / No	Is psych test a benefit? Yes / No												
	Opt Choice, MDIPA, Mamsi , Alliance CTP in or CTP NOT in schedule 1-2 wks out.	How many hrs allowed per year? Is a form needed? Yes / No 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:** _____