OFFICE USE ONLY
First Date of Tx: ______________
DSM Code#: _________________
Check here if returning patient

BETA Confidential Intake Form:

A. PERSONAL INFORMATION:

Patient Name: _________________________ Date of Birth: _______________________
Address: ____ Male Female
City/State/Zip: ________________________________ Home Phone: (_____) _________
Cell Phone: (_____) _________________ Office Phone: (____) ___________________
Email___________________________ Social Security Number: ____________________
My preferred way of rescheduling(circle one): call my work, call home, Email, call my cell
Primary Care Physician: ___________________ Office Phone: (____) _______________
Emergency contact:__________________ Phone: (____) ____________ Relation:_______

B. RESPONSIBLE PARTY: Fill in if under 18 or if someone other than patient is responsible for payment:

Name: ____
Address: ____
City/State/Zip: ____
Home Phone: (____) _________________ Business Phone: (____) __________________
Relationship to Patient: ____
Second Responsible Party: ____

C. INSURANCE INFORMATION:

Primary Insurance Company: ____
Address: ____
City/State/Zip: ____
Phone: (____) ____
Name of Insured (if different from patient): ______________________ DOB: ___/___/___
Insurance ID#: ______________________________ Group #: ______________________

Secondary Insurance Company: ____
Address: ____
City/State/Zip: ____
Phone: (____) ____
Name of Insured (if different from patient): ______________________ DOB: ___/___/___
Insurance ID#: ______________________________ Group #: ______________________

D. INSURANCE COVERAGE INFORMATION:

Annual Deductible: ____
Insurance Coverage Per Session: 100% 80% 50% Other ____________________
How much coverage per Calendar Year? $_____________ or Number of Sessions: ______
Copayment per Session: $____________________ Other: _________________________

(Continued on other side)

E. AUTHORIZATION INFORMATION:

Authorization #: ______________________ Number of Sessions Authorized: __________
Date Authorization Starts: _______________ Date Authorization Ends: ________________
For Authorization Call: (____) _______________ Ext. _____ Fax: (____) ____________
Authorization Covers Type of Service Codes (check all that apply):
90801 90806 90808 90847 96117 Other ______________________________

F. BILLING INFORMATION (Check all that apply):

Send Claims to Primary Insurance Send Claims to Secondary Insurance
Send Claims to Insurance but Collect in Full from: Patient or Responsible Party
Patient pays in full at session or Responsible Party pays in full at session
Send Bills for Copayments/Deductible to Patient or Responsible Party
Send HCFA form to Patient or Responsible Party
Special Instructions ____

G.

FINANCIAL POLICY
Appointment cancelled with less than 24 hour notice will be charged to me at the full fee per hour.

I am responsible for the entire balance of services performed regardless of whether there is insurance coverage. Secondary insurance will be billed as a courtesy.

I understand and agree to the above stated financial policy.

Signed: ____ Date: _____________________

H.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE:
I authorize the use of disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed: ____

I authorize payment of medical benefits to my provider for services performed.

Signed: ____ Date: ________________