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

BETA Confidential Intake Form:

PATIENT TO FILL OUT SECTIONS: A, B, C, G, H

A. PERSONAL INFORMATION:

Patient Name: _____ Date of Birth: _____
Address: _____ ☐ Male ☐ Female
City/State/Zip: _____ Email: _____
Home Phone: (_____) _____ Can we leave a message at this #?: _____
Cell Phone: (_____) _____ Work Phone: (____) _____
Preferred method of contact for scheduling change/notification:
Cell ___ Email ___ Home ___ Work ___
Social Security Number: _____
Emergency Contact Person: _____ Phone: (____) _____
Primary Care Physician: _____ Office Phone: (____) _____

Is there anything that you would like the therapist to know about your current situation or your goals for therapy? _____

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 and ID#: _____
Group # (if applicable): _____
Name of Insured (if different from patient): _____ DOB: ___/___/___

Secondary Insurance Company and ID#: _____
Group # (if applicable): _____
Name of Insured (if different from patient): _____ DOB: ___/___/___

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: _____

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 hours notice will be charged to me at $70 per visit.

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: _____