



NEW CLIENT INTAKE APPLICATION

(Please print clearly)

1. THERAPY WILL BE COVERED BY

- Private pay (skip sections 5 & 6 below) Insurance (if use insurance, WE REQUIRE 1) A PHYSICIAN'S SCRIPT/REFERRAL and 2) FRONT & BACK COPIES OF INSURANCE I.D. CARD)

2. PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Gender: Male Female Home Phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Patient's Diagnosis (prescribed by physician): _____

Mother's Name: _____ May we disclose your child's treatment information to this person? Yes No
May this person receives the coverage & benefits information? Yes No
May we email you the coverage & benefits information after verification? Yes No

Mother's Email (required): _____

Cell Phone #: _____ Work Phone #: _____ Other Phone #: _____

Father's Name: _____ May we disclose your child's treatment information to this person? Yes No
May this person receives the coverage & benefits information? Yes No
May we email you the coverage & benefits information after verification? Yes No

Father's Email (required): _____

Cell Phone #: _____ Work Phone #: _____ Other Phone #: _____

3. EMERGENCY CONTACT (must be different than parents listed above)

1. Name: _____ Phone #: _____ Relationship to Patient: _____

4. PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Ins. Phone # (Provider line): _____

Policyholder's Name: _____ DOB: _____ SSN: _____ Relationship to Patient: _____

Policyholder's Home Address: _____ Phone #: _____

Policy / Medicaid I.D. #: _____ Group #: _____

Policyholder's Employer Name (if applicable): _____

5. SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company: _____ Ins. Phone # (Provider line): _____

Policyholder's Name: _____ DOB: _____ SSN: _____ Relationship to Patient: _____

Policyholder's Home Address: _____ Phone #: _____

Policy / Medicaid I.D. #: _____ Group #: _____

Policyholder's Employer Name (if applicable): _____



6. REFERRING / PRIMARY CARE PHYSICIAN (if applicable)

Primary Care
Physician's Name: _____ Phone #: _____ Fax #: _____
Address: _____

Referring
Physician's Name: _____ Phone #: _____ Fax #: _____
Address: _____

7. ACKNOWLEDGEMENT

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf when using insurance. However, you are ultimately responsible for payment of your bill.

You agree that you will pay any applicable deductible, co-payment, and/or co-insurance as determined by your insurance plan(s). Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

Patient/Guardian – Print Name

Date:

Patient/Guardian – Signature

Date: