Nexus-FACTS FAMILY HEALING

Family, Adolescents, and Children Therapy Services

1385 Mendota Heights Rd, Suite 200, Mendota Heights, MN 55120 | Office: (651) 379-9800 Fax: (651) 405-0358 | facts-mn.org

Referral Intake

Date of Referral: ____________________

☐ **Outpatient Therapy (OP)**
☐ **Skills Services (CTSS)**
☐ **School Based Grant** **School Name:** **District:** **Grade:** ____________________
☐ **In-Home Therapy (IHTS)**
☐ **Intensive In-Home Therapy (CIBS/SFT/CRS)**
☐ **Preschool Day Treatment (PASS)**
☐ **Early Childhood Program (ECH)**
☐ **Parent Education Program (SST/PE)**

Client Information

Client Name: ____________________ Age: ________ DOB: ____________________

Client Address: ____________________

City: ____________________ State: ________ Zip Code: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Other: ____________________

Okay to leave message? Home ☐ Yes ☐ No Cell ☐ Yes ☐ No Other ☐ Yes ☐ No

Initial paperwork by: ☐ Email ☐ Mail ☐ Kiosk Email Address: ____________________ Sent: ☐ Yes ☐ No

Client Gender: ☐ Male ☐ Female Social Security Number: ____________________

Client Ethnicity: ☐ Caucasian ☐ African American ☐ American Indian ☐ Asian/ Pacific Islander ☐ Hispanic
☐ Other (Please Describe): ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner ☐ Other: ________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Disabled ☐ Active Military ☐ Other: ________

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a student

Primary Caretaker: ☐ Mother ☐ Father ☐ Both ☐ Other: ____________________

Legal Guardian: ☐ Mother ☐ Father ☐ Both ☐ Other: ____________________

Parent Information (If client is a child)

Mother's Name: ____________________ Father's Name: ____________________

Address: ☐ Same as above ☐ Different from above: ____________________
Address: ☐ Same as above ☐ Different from above: ____________________

Phone: ____________________ Phone: ____________________

Others living in the home:

Name:	DOB:	Gender:	Relationship to client:
1.		☐ M ☐ F	
2.		☐ M ☐ F	
3.		☐ M ☐ F	
4.		☐ M ☐ F	

Emergency Contact N ____________________ Number: ____________________ Relationship: ____________________

Referral Information

Referral Source: ____________________ Agency/Division: ____________________

Referral Email: ____________________ Referral Phone: ____________________

Fax: ____________________ Current Social Services/Probation/Psychological Services Involvement? ☐ Yes ☐ No

Date of last DA: ________ Within the last 6 months? ☐ Yes ☐ No Has client received any previous mental health services? ☐ Yes ☐ No

Clinic/Therapist: ____________________ Diagnosis: ____________________

Reason for Referral:

Date of 1st Call to Client: ____________________ **Date of 1st Appt:** ____________________

Patient Registration Form/Insurance Verification

Family Adolescents & Children's Therapy Services

Please provide front and back copy of all active insurance cards. (Enlarge if possible)

Client is Uninsured: ☐

Primary Insurance Coverage		***Secondary Insurance or EAP Coverage***	
Insurance Name:	______________	Insurance Name:	______________
Insurance Group/Account #:	______________	Insurance Group/Account #:	______________
Policy/Individual/Member #:	______________	Policy/Individual/Member #:	______________
1-800 #:	______________	1-800 #:	______________
Employer:	______________	Employer:	______________
Co-Pay Amount:	______________	Co-Pay Amount:	______________
Name of Policy Holder:	______________	Name of Policy Holder:	______________
Relationship to Policy Holder	☐ Self ☐ Spouse ☐ Child	Relationship to Policy Holder	☐ Self ☐ Spouse ☐ Child
(policy holder info):	☐ Other ______________	(policy holder info):	☐ Other ______________
Policy Holder DOB:	______________	Policy Holder DOB:	______________
Policy Holder Gender:	☐ Male ☐ Female	Policy Holder Gender:	☐ Male ☐ Female
Policy Holder Address:	______________	Policy Holder Address:	______________
Policy Holder City/State/Zip:	______________	Policy Holder City/State/Zip:	______________

For Office Use Only: Verification of Coverage and Benefits listed below

Effective Date of Coverage:	______________	Pre-Existing:	______________
Authorization Required:	______________	Maximum Out-Of-Pocket:	______________
Authorization #:	______________	Marriage/Family Therapy:	______________
# of Sessions Authorized:	______________	In/Out Network Benefits:	______________
Dates of Authorization:	______________	Electronic Payer ID #:	______________
Deductible/Spend Down:	______________		______________
Co-Pay/ Co-Insurance:	______________		______________
H2033 Coverage:		*Verified By:*	

Insurance Representative: ______________ Date and Time: ______________

*** Please note: This verification of coverage and benefits is not a guarantee of payment.***