Family, Adolescents, and Children Therapy Services

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

Insurance Name: ______________________

Insurance Group/Account #: ______________________

Policy/Individual/Member #: ______________________

1-800 #: ______________________

Employer: ______________________

Co-Pay Amount: ______________________

Name of Policy Holder: ______________________

Relationship to Policy Holder (policy holder info): ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Policy Holder DOB: ______________________

Policy Holder Gender: ☐ Male ☐ Female

Policy Holder Address: ______________________

Policy Holder City/State/Zip: ______________________

Secondary Insurance or EAP Coverage

Insurance Name: ______________________

Insurance Group/Account #: ______________________

Policy/Individual/Member #: ______________________

1-800 #: ______________________

Employer: ______________________

Co-Pay Amount: ______________________

Name of Policy Holder: ______________________

Relationship to Policy Holder (policy holder info): ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Policy Holder DOB: ______________________

Policy Holder Gender: ☐ Male ☐ Female

Policy Holder Address: ______________________

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.***