



Initial Contact Form

Call Taken By: _____ Date: _____ Time: _____
 Caller's Name: _____

Client Name _____ Social Security Number _____
 Age _____ Address _____ City/State/Zip _____
 Date of Birth _____ Home Phone _____ Cell Phone _____ Work Phone _____
 Employer _____ Emergency Contact Name/Phone Number _____
 Marital Status _____ Spouse's Name _____ Spouse's Employer _____ Spouse's Work Phone _____
 M F Best time to be reached: _____ Leave a message if you are not at home: Yes No
 May we add you to our general mailing list for newsletters and announcements? Yes No

Referral Source (How did you get our name?) _____
 Therapist Requested: _____ Office Requested: PH Clinton Twp
 Best Time to Meet with Therapist: _____
 What type of treatment are you requesting (check as many as apply)?
 Family Marital Individual Group Pastoral

Bill Insurance Sliding Fee
 A reduced rate is available when requested. What is your annual household income?

| | |
|--|---|
| <i>Income</i> | <i>Fee (Regular session/Assessment session)</i> |
| <input type="checkbox"/> \$120,000 and above | \$110/\$125 |
| <input type="checkbox"/> \$60,000-\$119,999 | \$100/\$115 |
| <input type="checkbox"/> \$35,000 -59,999 | \$85/\$100 |
| <input type="checkbox"/> Under \$34,999 | \$70/\$85 |

Primary Insurance _____ Subscriber (if different from patient) _____
 Subscriber DOB _____ Subscriber SS# _____
 Policy # _____ Group # _____
 Provider Phone # _____ Effective Date _____
 Provider Address _____
 Employer _____

Secondary Insurance _____ Identification/agreement/policy # _____
 Subscriber (if different from patient) _____
 Subscriber DOB _____ Subscriber SS# _____

EAP Carrier _____ Authorization # _____
 EAP Contact Number _____ No of Sessions _____

| Status of the Call | | Notes |
|---|--|-------|
| Date and Time _____ | <input type="checkbox"/> Describe Business Hours | |
| Date Accepted _____ | Appt. Date/Time _____ | |
| Scheduled With _____ | Date Accepted by Therapist _____ | |
| Program <input type="checkbox"/> Ministry <input type="checkbox"/> Clin <input type="checkbox"/> Groups | | |

| Genogram/Presenting Problem: | Call to Insurance Company |
|--|---|
| <p>Are you presently taking any psychotropic medications? _____</p> <p>Previous Hospitalizations for Mental Health? _____</p> <p>Are your concerns substance abuse related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, client was informed that they will be required to complete a physical exam within two weeks of intake</p> | <p>Tax ID# 20-3345562</p> <p>Call By _____</p> <p>Date _____</p> <p>Number _____</p> <p>Talked to _____</p> <p>Transferred to _____</p> <p>Transfer # _____</p> <p>Billing Address: _____ _____ _____</p> |

| Insurance Benefits | |
|--|------------------------------|
| <p>Mental health same as major medical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, mental health carrier _____</p> <p>Policy # for mental health carrier _____</p> <p>In Network <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Deductible Amount _____</p> <p>Deductible Met _____</p> <p>Copay (flat amount) _____</p> <p>Coinsurance (percentage) _____</p> <p>Number of Sessions</p> <p>Yearly Max _____</p> <p>Sessions Used _____</p> <p><input type="checkbox"/> Precertification/Preauthorization/OTR Required</p> <p><input type="checkbox"/> Precertification/Preauthorization/OTR Obtained</p> <p>Authorization # _____</p> <p>Dates of Initial Authorization _____</p> <p># of Sessions Approved _____</p> | <p>Notes/Comments</p> |