Susan Dellutri, LLC 827 N. Cass Street, Milwaukee, WI 53202 (414) 278-7980

Information Form For Child/Adolescent

Therapist:_____ Intake Date: _____

Name: _____ Date of Birth: _____
Address: _____ Gender: _____
City/State/Zip: _____

Father's Name _____ DOB _____
Address:_____
_____
Phone: Home (_____) _____Work: (____) _____
Cell Phone: (_____) _____
Relationship Status: M D S W P (Partnered)
Father may be contacted at home _____ work _____

Mother's Name _____ DOB _____
Address:_____
_____
Phone: Home (_____) _____Work: (____) _____
Cell Phone: (_____) _____
Relationship Status: M D S W P (Partnered)
Mother may be contacted at home _____ work _____

*I have specified contact/communication concerns on back of form: Yes or No (circle one)

Emergency contact person: _____ Phone ( )_____
Referred to therapist/Therapies East by _____
Bills should be sent to _____
Payment Information: (Please check) Self Pay ___ Insurance ___ MSA ___ HSA ____ Other ____

Insurance Information

Primary
Name of Insurance Co. _____
Policy Holder _____
Effective Date _____
Employer _____
ID#/Group# _____
Type of Coverage Single/Family
Claims Address _____
Phone Number _____

Secondary
Name of Ins. Co._____
Policy Holder _____
Effective Date _____
Employer _____
ID#/Group#_____
Type of Coverage Single/Family
Claims Address _____
Phone Number _____

Benefits
In Network ____ Out of Network ____
Preauth needed for sessions? yes ___ no ___
Authorization # _____
Number of sessions authorized _____
Authorization dates _____to _____
Deductible $ _____
Copay per session $ or % _____
Coinsurance _____%
Benefits for calendar year $ _____

In Network ____ Out of Network ____
Preauth needed for sessions? yes ___ no ___
Authorization # _____
Number of sessions authorized _____
Authorization dates _____ to _____
Deductible $ _____
Copay per session $ or % _____
Coinsurance _____%
Benefits for calendar year $ _____

ASSIGNMENT OF BENEFITS: Since my health insurance may cover the cost of service, I hereby authorize Therapies East Associates, LLP to release to my insurance company and/or associated professionals only pertinent billing/diagnostic information from my medical records which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to TEA for services rendered. **I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits.**

Signature_____ Date _____