

Information Form for Adults

Therapist: _____

Intake Date: _____

Name: _____

Home Phone: () _____

Address: _____

Email address: _____

City/State/Zip: _____

Date of Birth: _____

SS#: _____

Occupation: _____

Work Phone: () _____

Employer: _____

Cell Phone: () _____

Address: _____

Gender: _____

City/State/Zip: _____

Relationship Status: S M D W P (partnered)

I 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 _____