Therapies East Associates, LLP 827 N. Cass Street, Milwaukee, WI 53202 (414) 278-7980

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 ___
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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 ________________________