Therapies East Associates, LLP 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 ________________________