

LAST NAME: _____ FIRST NAME: _____ MI: _____

DEMOGRAPHICS:

DOB: ____/____/____	Referring MD:
SSN: ____-____-____	MD PHONE:
HOME #:	MD FAX:
CELL/WORK #:	NPI #:
ADDRESS:	_____ Script Received _____ Patient to Bring Script Rx Date: _____ _____ Script to be Faxed * Diagnosis: _____
EMERGENCY CONTACT: Name: _____ Phone: _____ Relation: _____	APPT TIME PREFERENCE:

INSURANCE INFORMATION:

Primary Insurance:	Policy ID#: _____ Group #: _____
Policy Holder:	Effective Date:
Preauthorization Required: YES NO	Authorization #:
Authorized Dates: _____ to _____	# visits authorized:
Deductible Amount: \$ _____ Ded paid to date: \$ _____ / MET ----- OOP Amount: \$ _____ OOP paid to date: \$ _____ / MET	Co-Insurance coverage: _____% / _____% pt Max \$ or visits: _____ remaining: _____ ----- Co-Pay: \$ _____
Rep Name:	Date: _____ Time: _____

Secondary Insurance:	Policy ID#:
Policy Holder:	Effective Date:
Coverage of Primary DED: Y / N	Coverage of Primary Co-Ins: Y / N

NOTES	Rep Name: _____ Date: _____ Time: _____
-------	--

Evaluation: _____ Time: _____ Therapist: _____