INTAKE & INSURANCE FORM

Date: _____

Name: _____

Patient Date Of Birth: _____ Gender: M F (circle one)

Parent/Spouse: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Marital Status: Single Married Widowed Divorced Other: _____

Were you referred to Calm and Sense Therapy? Yes No If yes, by whom _____

_____

REQUIRED INSURANCE INFORMATION: Please complete this section if you would like us to bill your insurance provider. We will bill your insurance provider as a courtesy. If they fail to pay you are responsible for any uncovered costs. Please present your insurance card. Calm and Sense Therapy fee is $150.00 per session. Co-pay/fee is due at the beginning of each session.

Insurance Co.: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Plan/Group #: _____ Member ID#: _____

Relationship of Policyholder to Patient: _____

Policyholder Address: (if different than patient) _____

Name, Phone & Relationship of a close relative/friend to alert in an emergency:

_____

WE DO NOT MAKE REMINDER CALLS
24-HOUR NOTICE OF CANCELLATION IS REQUIRED TO AVOID FULL CHARGE

OFFICIAL USE
Calm & Sense Therapy
DX: _____