Capital Therapy Services

Patient Intake Form

PATIENT INFORMATION

Child's name: ______________________________ Date of Birth: ______________________

Address: ____ Phone: __________________

City: ____ Zip Code: ________________

Father/Guardian name: ____________________ Age: _______Parent's occupation: ______________

Mother/Guardian name: ____________________ Age: _______Parent's occupation: ______________

Primary Care Physician ____________________ Practice Group Name______________________

Address____Zip______________

Phone number_____________________________________ Fax Number__________________

Any diagnosis of any kind?____

How did you hear of us?____

Primary Insurance:

Co. Name ____

Insurance ID # ______________________Insurance Group # ________________

Insurance Phone # ____________________________

Insured's Name _____________________Insured's DOB ______________Insured SS#_____________

Insured's Address ____

Insured's Phone ___________________Insured's Employer's Name ___________________________

****Each patient is responsible for knowing their insurance coverage benefits.****

Deductible: ____________ Has the deductible been met? ______ Co-Pay Per Session for specialists? _______

Visits Allowed: __________ Number of Visits Used this Year ________ Are evaluations covered? _____

Is Preauth for services Required? _________ Is a Prescription for Services Required?______

Secondary Insurance:

Co. Name ____

Insurance Group # _______________Insurance ID # ______________Insurance Phone # _______________

Insured's Name _____________________Insured's DOB ______________Insured SS#_____________

Insurance co-payments are due at the time of service.

Certification and Authorization

I certify that the above information is correct. I hereby authorize Capital Therapy Services to furnish my insurance carrier any information acquired in the course of the evaluation or treatment necessary to complete the insurance forms. Also, I hereby assign to Capital Therapy Services all payments for services rendered. In the event that my insurance company does not pay for services rendered, I understand that I am fully responsible for all payments due.

Responsible Party Signature: ____________________________________ Date: __________________

(Relationship to patient)____