

CLIENT INFORMATION

Last Name: _____

First Name: _____

MI: _____

(If under 18 years old) Name of Parent(s): _____

Client's DOB: _____ Age: _____

Mailing Address:

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell: () _____

Okay to leave voice message? Y/N

Okay to leave voice message? Y/N

Okay to leave text message? Y/N

Okay to leave text message? Y/N

E-mail: _____

Name of Primary Care Physician (PCP):

Phone Number of PCP: _____

Emergency Contact:

Name: _____

Relationship: _____ Phone: () _____

INSURANCE INFORMATION

Insurance Company, Policy Type, and Plan Description (e.g., "Anthem HMO Enhanced"):

ID #: _____ Group #: _____

Claim Address:

Phone numbers on back of card:

Does your policy cover the following "mental and behavioral health" services at this practice location (Dr. Chance in Durham, NH, 03824)? Please confirm and circle Y or N.

"Initial Evaluation"? Y N "Individual Psychotherapy" - 60 or 45 minutes or both? Y N

"Family/Conjoint Therapy"? Y N "TelePsychology"? Y N

Outpatient Mental Health **Authorization** Needed?: Y N

Copay: _____ Deductible: _____

Authorization # for initial sessions(s) if applicable:

Expiration Date: _____ # of Visits: _____ Annual MAX # visits? _____

Is this a “parity” policy (i.e., no annual max for certain “bio-based” diagnoses)? Y N

Relationship to Policy Holder: Self _____ Spouse _____ Child _____ Other _____

Policy Holder’s Name:

Policy Holder’s Address:

Policy Holder’s DOB: _____

Policy Holder’s Phone #: _____

Secondary Insurance Information (if applicable):

Plan type and description: _____

ID #: _____ Group #: _____

Claim Address:

Phone numbers on back of card:

Outpatient Mental Health Authorization Needed?: Y N

Copay: _____ Deductible: _____

Authorization #: _____ Expiration Date: _____

Relationship to Policy Holder: Self _____ Spouse _____ Child _____ Other _____

Policy Holder’s Name:

Policy Holder’s Address:

Policy Holder’s DOB: _____

Policy Holder’s Phone #: _____