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 <u>at this practice location</u> (Dr. Chance, 8 Jenkins Court, Suite 402-1, 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):
_____
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: _____

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: _____