NEW PATIENT REQUEST

For office use only:

DATE CLIENT: _____ DATE OFFICE: _____ INITIAL APPT: _____ PROVIDER: _____
CALLED/EMAILED CALLED BACK DATE/TIME LOCATION: _____

NAME OF CLIENT: _____DOB: _____ AGE: _____

ADDRESS: _____COUNTY:_____

CELL #: _____ HOME #: _____ EMAIL: _____

PREFERENCE: VM TEXT EMAIL GENDER: _____ MARRIED: Y / N

REFERRED BY: _____ PROVIDER REQUESTED: _____

RESPONSIBLE PARTY NAME, ADDRESS, AND NUMBER IF DIFFERENT: _____

_____

REASON FOR SEEKING SERVICES: _____

PRIMARY INSURANCE: _____ PLAN: PPO/HMO _____

POLICY HOLDER/SUBSCRIBER: _____ DOB: _____ EMPLOYMENT: _____

ID #: _____ GROUP #: _____ CUSTOMER SERVICE #: _____

RELATIONSHIP: _____ SUBCRIBER ADDRESS: _____
TO SUBSCRIBER AND NUMBER (if different) _____

SECONDARY INSURANCE: _____ PLAN: PPO/HMO _____
(MEDICARE PRIMARY: Is crossover set up? ___ Yes ___ No ___ Told client to set up)

POLICY HOLDER: _____ DOB: _____ EMPLOYMENT: _____

ID #: _____ GROUP #: _____ CUSTOMER SERVICE #: _____

RELATIONSHIP: _____ SUBCRIBER ADDRESS: _____
TO SUBSCRIBER AND NUMBER (if different) _____

EAP: _____ AUTHORIZATION #: _____

 # OF SESSIONS: _____ START: _____ END: _____ CUST SERV #: _____

POLICY HOLDER: _____ DOB: _____ EMPLOYMENT: _____

For office use only:

___ Create Account ____ Check Insurance ____ Check 2nd ____ Give appt ___Patient Ally ___Comp-lete acct ___Parent Account ____ Print Demograp ____ PR Sheet ____ Make File

For office use only:

PRIMARY INSURANCE BENEFITS:

INSURANCE CO: _____ PAYER ID: _____ PHONE: _____

CLAIMS ADDRESS: _____

CONTACT: _____ VISIT LIMIT: _____ EFF DATES: _____ CALENDAR/ CONTRACT_____

DEDUCTIBLE: _____ COINS: _____ COPAY: _____ OOP: _____ TELEHEALTH: _____

REFERRALS NEEDED? _____ AUTHORIZATIONS? _____ LIFETIME MAX: _____

REFERENCE #: _____ IN NETWORK PROVIDER (S): _____

SECONDARY INSURANCE BENEFITS: (MEDICARE PRIMARY: Crossover set up? ___ Yes ___ No ___ Told client)

INSURANCE CO: _____ PAYER ID: _____ PHONE: _____

CLAIMS ADDRESS: _____

CONTACT: _____ VISIT LIMIT: _____ EFF DATES: _____ CALENDAR/CONTRACT

DEDUCTIBLE: _____ COINS: _____ COPAY: _____ OOP: _____ TELEHEALTH: _____

REFERRALS NEEDED? _____ AUTHORIZATIONS? _____ LIFETIME MAX: _____

REFERENCE #: _____ IN NETWORK PROVIDER (S): _____

TESTING BENEFITS / COVERAGE:

BENEFITS: _____

AUTHORIZATION: _____ HOURS: _____ EFF DATES: To:_____From:_____

CONTACT: _____ REFERENCE #: _____

ANY ADDITIONAL INFORMATION?

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