Appt. scheduled for:

Cherie Mannino, LISW
counseling & therapy services

PART 1

Registration Information

Referred by _____ Reason _____ Date _____

New Client Name_____ Social Security # ____/____/_____ Phone_____

Responsible Party_____ School or Work Place_____

Address_____ City_____ Zip_____ Work Phone _____

Place of Employment (or School) _____Grade _____

Marital Status: Married / Single / Divorced / Widowed Age:____ Male / Female Date of Birth_____

Email: _____ ☐ Permission to communicate by email

☐ Permission to leave voice message

PART 2

Insurance Policy Information

Name of Insured _____ Relation to Client _____ Date of Birth_____

Address of Insured_____

Employer _____ Status: FT PT On leave

Plan Name _____ Policy ID # _____ Group # _____

Insurance Co. Phone #'s_____, _____

PART 3

Insurance Eligibility & Benefits Information

Date of Call ____/____/____

Insurance Co. Name_____ Phone # (____)_____

Managed Care Company_____ Phone # (____)_____

Contact Person _____ Reference #_____ Effective date _____

Claims Address …….. _____

Is therapist in the Network? Yes / No _____

Do they reimburse out of network providers? YES / NO Primary Care Physician is _____

Portion paid by insurance_____ Pre-Authorization # _____

At what rate or percent of what amount _____ Total # of sessions limited to_____

What is the deductible _____ Amount met to this date ___/___/___, $ _____

What is clients co-payment _____ Limit per year / lifetime max _____

Timely filing limit: _____ Provisional diagnoses _____ 90791

Notes: 90837

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