INTAKE/VERIFICATION OF BENEFITS

Appt Date:_____ Appt Time: _____ Intake Date: _____

Patient's Name:_____ Patient's DOB: _____

Address: _____ Male __ Female __

Home Phone: _____ Work Phone: _____ Cell: _____

Referring MD: _____ Ref MD Phone: _____

Diagnosis: _____ Script Date: _____

Patient's Email Address: _____ PT: ____ OT: ____ ST: ____

Parent Name: Mom: _____ Dad:_____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID#: _____ Subscriber Group #: _____

Start Date:_____Expiration Date: _____

Auth # _____# Visits_____
Units_____

Patient's Signature: _____ **Date:** _____