Wellness Therapy Center
SPECIALIZED AUTISM & BEHAVIORAL CARE

Intake Paperwork

PATIENT INFORMATION:

Date_____ Client's Social Security #_____ Case # _____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip _____

Telephone (Home)_____ (Work) _____

Birthdate_____ Age_____ Gender ____F ___M Race_____

Name of Spouse/Guardian _____ Phone _____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. # _____

Signature of Person Responsible for Payment X_____(Must be signed for services to begin)

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, CONTACT:

Name (1)_____ Relationship_____ Phone_____ Work_____

Address_____ City_____ State_____ Zip_____

Name (2)_____ Relationship_____ Phone_____ Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

Current Medications _____

Allergies_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____ Hrs._____

Spouse: Place_____ Phone_____ Hrs._____

INSURANCE INFORMATION

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company:_____Secondary Insurance Company: _____

Card Holder_____Card Holder _____

Birth Date _____ Birth Date _____

SSN _____ SSN _____

Address _____ Address _____

Phone # _____ Phone # _____

Employer _____ Employer _____

Policy ID # _____ Policy ID # _____

Group # _____ - _____ Group # _____ - _____

REFERRAL SOURCE

HOW DID YOU HEAR OF OUR CLINIC (OR FROM WHOM)? _____

Address _____ City _____ State _ Zip _____

Phone _____ Relationship to referral source _____ Primary doctor _____

RESTRAINING ORDER OR ORDER OF PROTECTION

Is there currently a Restraining Order or Order of Protection on anyone? YES / NO

If so, what is the name of the individual(s)? _____

BILLING INFORMATION – Read and sign:

1. I authorize Wellness Therapy Center to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, Wellness Therapy Center Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Wellness Therapy Center to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to Wellness Therapy Center
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) _____

Signature of person completing this form _____ Date: _____

Relationship to Patient: _____