INTAKE CALL / THERAPIST

☐ **APPOINTMENT ADDED TO INSYNC SCHEDULE**

☐ New Patient ☐ Returning Pat. ☐ Request for Copy of Benefits from Clinician_____and PT Name_____

Appointment with:_____ Date of Appointment:_____ Time:_____:_____☐am ☐pm

Office Location: ☐Schaumburg ☐Vernon Hills ☐Crystal Lake ☐Telehealth – Must be in Illinois at time of appointment

Patient Legal* Name:_____ D.O.B._____-_____-_____ Age:_____ Gender per Insurance:☐M ☐F

Preferred Name:_____ Preferred Pronoun:☐He ☐She ☐They ☐None Current Gender Identity:☐M ☐F ☐Non-Binary

Patient SS#:_____-____-_____ Contact Method preferred for benefit results: ☐Home # ☐Cell ☐Email

Patient gives permission to leave Phone Messages on: ☐Home ☐Cell ☐Other _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Mom/Dad Cell: (_____) _____-_____ Other Phone: (_____) _____-_____ Other Phone Name: _____

Caller Name:_____ Phone (if different from above):(_____) _____-_____

Caller's relationship to patient: ☐Parent ☐Spouse ☐Guardian ☐Partner ☐POA ☐Other_____

Street Address:_____ Email:_____

City:_____State:_____Zip Code:_____ County:_____

***LEGAL name refers to the NAME THAT APPEARS ON INSURANCE CARD**

For request of Benefits only – Address / phone numbers and insurance confirmed?? ☐Y ☐N ***Must Do!***

CLINICAL SECTION

Referral Information (Be Specific):_____

Clinical Reason for Seeking Treatment:_____

Marital Status of Parents (patient 17 & under): ☐M ☐D ☐W ☐S

If Divorced: Do both parents have legal rights to consent for Treatment? ☐Yes ☐No (not custody but legal parental rights)

If yes, both parents must sign Authorization and Consent Form on both pages. Also Clarify Financial Policy:

TELEHEALTH: ☐Patient in Illinois ☐Patient understands sessions are in secure place

FINANCIAL SECTION

☐ Self Pay - NOT billing through insurance

☐Good Faith Estimate Reviewed

Patient Copy Via: ☐ Copy Declined ☐ Mail ☐ Email ☐ Portal

Medicare Patients - Red, White, Blue Card?☐Yes ☐No **Effective Date of Medicare _____-_____-_____ (on Card)**

Medicare Patients - Are they part of QMB? ☐ No ☐Unsure ☐Yes - if Yes, Cannot Take.

Insured/Policy Holder First and Last **LEGAL*** Name:_____

Insured/Financial Responsibility address if different from patient: Insured/Responsible Party Phone (_____) _____-_____

Street Address:_____

City:_____State:_____Zip Code:_____ County:_____

Insured Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Step-Parent ☐Other:_____

Insured SS #:_____-_____-_____ Insured D.O.B: _____-_____-_____

Insurance Name:_____ ☐PPO ☐HMO ☐POS ☐Blue Choice?

Insured ID Number:_____ HMO Site Number:_____

Group/Policy Number:_____ Insured Place of Work_____

Insurance Customer Service /Eligibility #: (_____) _____-_____ ☐UBH ALERT Sent to Patient if UHC/UBH Insurance

NOTES / COMMENTS / SPECIAL INSTRUCTIONS:

Special request benefit verification additional for: ☐Psych Testing (all codes) ☐Group ☐Marital / Couples ☐EAP ☐Telehealth

FORMS SENT TO PATIENT VIA:

☐ Portal Link Sent ☐Forms Download from Website /DropBox ☐Bring in forms in person

Account Balance Cleared For All Family Members ☐Yes ☐No ☐Medicare/QMB, checked online _____(Initials)

Confirmation of benefits explained to patient and copay prior to appointment ☐Yes ☐No Self-Pay ☐Good Faith Estimate Done

Benefit Specialists Initials:_____ Date of Call:_____ Contact Type: ☐LM ☐TTRP

Intake Done By: _____ Date:_____ Time:_____:_____ ☐am ☐pm