Patient **LEGAL*** Last Name:_____Account #_____Entered in Scheduler:_____

INTAKE CALL / BENEFIT VERIFICATION WORKSHEET

☐ 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

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#:_____ Pt refused to give SS#: ☐ Yes ☐ No If yes, Give SS# omit Policy _____

Patient gives permission to leave Phone Messages on: ☐Home ☐Cell ☐Work ☐Other Phone (_____) _____-_____

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

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

How would you like to receive MD Reminder calls: ☐Text ☐Phone Call If Phone, What #? (_____) _____-_____

What number should we call to give benefit results: ☐Home ☐Cell ☐Work ☐No call needed

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

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

Street Address:_____

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:

For Minors - Instruct need for Parents (at least one) to be present at appointment? ☐Yes ☐No

College student screen (17 - 26): Is patient a student? ☐Yes ☐No Are they local? ☐Yes ☐No

Geriatric Assessment - Can you speak with patient & complete intake? ☐Yes ☐No If Yes, can schedule.

If Patient has Dementia / Alzheimer's, refer out for treatment.

Transfer Patients - Why transferred _____

Both MD's reviewed chart/agreed: Date: _____/_____/_____ Balance cleared for all family members: _____ initials

Benefits up to date? ☐Yes ☐No Date last seen: _____/_____/_____ Remove Flags/Old Notes: _____ initials

FINANCIAL SECTION

☐ Self Pay - NOT billing through insurance explained. ☐Yes ☐No

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

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

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

Insured/Financial Responsibility address if different from patient:

Street Address:_____

City:_____State:_____Zip Code:_____ County:_____

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

Insured SS #:_____ Insured D.O.B:_____-_____-_____ Refused SS#: ☐Yes ☐No

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

Insured ID Number:_____ HMO Site Number:_____

Group/Policy Number:_____ Insured Place of Work:_____

Insurance Customer Service /Eligibility #: (_____) _____-_____ Behavioral Health #: (_____) _____-_____

NOTES / COMMENTS / SPECIAL INSTRUCTIONS:

☐ Cancellation Policy on Evals reviewed_____(initials)

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

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

Confirmation of benefits explained to patient and copay prior to appointment ☐Yes ☐No

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

Intake Done By:_____ Date:_____ Time:_____:_____ ☐am ☐pm Will download from website: ☐Yes ☐No