

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 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#: _____ - _____ - _____ Pt refused to give SS#. Patient Informed of Waiting Room Policy and Rules. If issues do not schedule Not Negotiable
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 Cell Phone Home Phone Email (used for MD Appt. Only)
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 POA Other _____
Street Address: _____ Email (MD Appt. Only): _____
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 – Talk to patient – Aware coming to appointment? Yes No Has POA Healthcare w/mental health Yes No
Name of POA _____ Relationship to Pt _____ Copy of POA before appt discussed Yes No ?
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
ADHD ADULT EVALUATIONS: Aware testing may be required to receive stimulant. _____ initials
If treated previously, bring prior medical records (lqbal) _____ 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 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: _____ - _____ - _____ 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 #: (____) _____ - _____

NOTES / COMMENTS / SPECIAL INSTRUCTIONS: Cancellation Policy on Evals reviewed _____ (initials)
Special request benefit verification additional for: Psych Testing (all codes) Group Marital / Couples EAP Telehealth

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
Benefit Specialists Initials: _____ Date of Call: _____ Contact Type: LM TTRP
Intake Done By: _____ Date: _____ Time: _____:_____ am pm Will download from website: Yes No