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:_____
Office Location: ☐Schaumburg ☐Vernon Hills ☐Crystal Lake

Patient Legal* Name:_____ D.O.B._____-_____-_____ Age:_____ Gender: ☐M ☐F
Patient SS#:_____-_____-_____ Pt refused to give SS#: ☐Yes ☐No If yes, Give SS# omit Policy _____
Home Phone: (_____) _____-_____ Cell Number: (_____) _____-_____
Work Phone: (_____) _____-_____ Mom/Dad Cell: (_____) _____-_____
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 ☐Work ☐Cell ☐ No call needed
Caller Name:_____ Phone (if different from above):(_____) _____-_____
Callers relationship to patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ 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. 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: _____/_____/_____

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 <u>if different from patient</u>:
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 #: (_____) _____-_____

<u>NOTES / COMMENTS / SPECIAL INSTRUCTIONS:</u> ☐ Cancellation Policy on Evals reviewed_____(initials)
Special request benefit verification additional for: ☐Psych Testing ☐Group ☐Biofeedback

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:_____ Will download from website: ☐Yes ☐No