MR #:_____

Provider:_____

Date:_____

Time:_____

Patient Information

Patient Name: _____

Social Security #: _____ DOB: _____

Phone (H): _____ Phone (C): _____

Address: _____

Email: _____ Referring Doctor: _____

Referring Doctor Phone #: _____ Specialty: _____

Prior Psychiatric Diagnosis: _____

_____

Past Psychiatric Hospitalization ☐ Yes ☐ No

Reason: _____

Dates: _____

Hospitalized Where: _____

Current Psych Meds: _____

What services are you seeking within our clinic?

☐ Medication Management
☐ Individual therapy
☐ Family Therapy
☐ Diagnosis
☐ Other: _____

Insurance & Benefit Information

Insurance Company: _____

Policy/Member ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Phone: _____

Is Provider: ☐ In Network ☐ Out of Network ☐ Deductible: _____ **Met?** ☐ Yes ☐ No

Visit Limit: _____ Effective Date: _____ Copay: _____

Secondary Insurance: ☐ Yes ☐ No

Sheppard Pratt
HEALTH SYSTEM

Claims Address: _____

Pre-cert Required? ☐ Yes ☐ No **Auth Required:** ☐ Yes ☐ No

Fax Treatment Plan To: _____ Per: _____ Date: _____

Comments: _____

Secondary Insurance Company: _____

Policy/Member ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Phone: _____

Authorization Information

Per: _____ Date: _____

Procedure Code: _____ # of Sessions: _____

Begin Date: _____ End Date: _____

Authorization #: _____

Per: _____ Date: _____

Procedure Code: _____ # of Sessions: _____

Begin Date: _____ End Date: _____

Authorization #: _____

Comments: _____

_____

_____