

Colony Care Behavioral Health

113 Belmont St, Belmont, 02478 Phone 781-431-1177 Fax 781-431-1181
11 River Street Wellesley, MA 02481 Phone 781.431.1177 Fax 781.431.1181
841 Main Street Walpole, MA 02081 Phone 508.660.6699 Fax 508.660.6658

Initial Intake Face Sheet Form

Today's Date: _____ Provider I am seeing today: _____

Patient Name : _____ **DOB**: _____ **Age**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone : _____ **Cell(Self/Parent)**: _____

Responsible Party if Pt. is Minor: _____

Employer: _____ **Work Phone**: _____

If Student, Where/Grade: _____ **E-Mail Address**: _____

Emergency Contact: _____ **Phone #**: _____

Primary Care Provider: _____ **Phone #**: _____

PCP Address : _____

Current Medications: _____

Name, #, and address of Professional that referred you: _____

Patient's Insurance Company: _____ **Card #**: _____

Insurance Phone #: _____ **Initial Copay/Extended Copay** : _____

Subscriber: _____ **Subscriber's DOB**: _____

Subscriber's Social Security #: _____ **Subscriber's Relation to Patient**: _____

Subscriber's Address if different than patients: _____

Insurance Group #: _____ **Subscriber's Employer**: _____

Authorization #: _____ **# of Sessions**: _____

Effective Date: _____ **Expiration Date**: _____ **Total # Session Per Yr Benefit**: _____

If there is secondary insurance, Ins. Co. Name: _____

Card Number: _____

I hereby authorize by my signature that:

1. _____ (Y/N) My therapist may contact and coordinate my treatment with my Primary Care Physician.
2. _____ (Y/N) As insured or authorized person, I hereby assign any insurance benefits to Colony Care and authorize them to furnish any necessary information needed to submit and process claims to my insurance company.

Patient/Legal Guardian Signature: _____ **Date**: _____