

Colony Care Behavioral Health

11 River Street Wellesley, MA 02481 Phone 781.431.1177 Fax 781.431.1181

Initial Intake Face Sheet Form

Please Print

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 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: _____

For Staff Use:

Dx #Code: _____