



Intake Paperwork

PATIENT INFORMATION:

Date _____ Client's Social Security # _____ Case# _____
Client's First Name _____ LastName _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate _____ Age _____ Gender _____ F _____ M _____ Race _____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____
Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, CONTACT:

Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Other Physicians _____ Phone _____
Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs. _____
Spouse: Place _____ Phone _____ Hrs. _____

INSURANCE INFORMATION

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: _____ Secondary Insurance Company: _____
Card Holder _____ Card Holder _____

Birth Date _____

Birth Date _____

SSN _____

SSN _____

Address _____

Address _____

Phone # _____

Phone # _____

Employer _____

Employer _____

Policy ID # _____

Policy ID# _____

Group # _____ - _____

Group# _____ - _____

REFERRAL SOURCE

HOW DID YOU HEAR OF OUR CLINIC (OR FROM WHOM)?

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship to referral source _____ Primary doctor _____

RESTRAINING ORDER OR ORDER OF PROTECTION

Is there currently a Restraining Order or Order of Protection on anyone? YES / NO

If so, what is the name of the individual(s)? _____

BILLING INFORMATION – Read and sign:

1. I authorize Rise Autism LLC to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, Rise Autism LLC Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize Rise Autism LLC to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to Rise Autism LLC
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) _____

Signature of person completing this form _____ Date: _____

Relationship to Patient: _____