



## 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: \_\_\_\_\_