Patient Portion

NEW PATIENT INTAKE FORM

Date of Call:	Logged In: [redacted] RLA Portion
Name:	Appt. Made By:
Address:	Self ( ) Parent ( ) Facility ( )
City:	*If Facility - Name & Phone #*
State:	
Zip Code:	Policy Effective Date:
Home Phone:	
Cell Phone:	If Medicaid , What County:
Work Phone:	Mont. ( ) Bucks ( ) Delaware ( )
Date of Birth:	
Social Security #	Deductible: Yes ( ) No ( )
Insurance Company (Primary):	Amount $ Has Been Met (Y) (N)
ID #	
Insurance Company (Secondary):	CoPay Amount $
ID #	# of Visits per year:
Nature of Problem:	S. M. I Benefits: Yes ( ) No ( )
1st Appt. Offered:	How many per year?
Date Refused:	Flex Benefits: Yes ( ) No ( )
Therapist/Psychiatrist:	How many outpatient? ( )
	How many inpatient? ( )
Appt. Date & Time	*Authorization #*
Ron Lewis Associates *Highland Office Center* *550 Pinetown Road, Suite 350* *Ft. Washington, Pa 19034*	Authorization Effective Dates: Date Start: Date Expired:
	Claims Address:

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