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: _____ Gender: _____

Address: _____ City: _____ State _____ Zip:_____

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

E-Mail Address: _____

Responsible Party if Pt. is Minor: _____

Emergency Contact Name and Number: _____

Primary Care Provider: _____ Phone #: _____

PCP Address: _____

Medication and Prescriber: _____

Medical Issues: _____

Referral Source: _____

Patient's Insurance Company: _____ Card #: _____

Initial Copay/Extended Copay: _____

Subscriber: _____ Subscriber's DOB: _____

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

Subscriber's Address if different than patients: _____

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:_____