A STEP AHEAD PEDIATRIC THERAPY, Inc.

INTAKE FORM

Date Referred: ______________ Intake By: __________________
Patient Name:__________________________Sex:M/F Birth Date:______________ S.S:________________
Guardian Name: ________________________ Street:_________________________________
City: _______________ State: ______ Zip: ___________ Phone Number: _________ Work: __________
Emergency Name & Number: ____
____
____

MARKETING REFERRAL SOURCE:
Name: ________________________ Company: ______________________
Street: ___________________________ City: _________ State: ______________ Zip: ___________
Reason for Referral: ____OT ____PT ____ST
____Eval & TX ____Eval only ____TX only ____Clinic ____Home Based
Diagnosis (chief complaint): ____
ICD 9 Code(if available): ____
DURATION OF TREATMENT/M.D. INSTRUCTIONS:
____
____

TREATING PHYSICIAN:
Name(first and last): ____
Address: ____
Phone: _________________ Fax: _______________________ Zip: ____________________

PAYMENT FOR SERVICES:
______ Private Pay
______ Insurance
Primary Insurance: ________________________ Phone: ____________________
Address: ____
CONTACT: __________________ Cover out – of - Network Services? ______________
Policy Holder: ____________________ Work Phone: ___________________
Policy Group Number: _________________ Policy Member Number: ___________________
Employer: ____
PRIOR AUTHOR. REQUIRED? ______ DEDUCTIBLE: ______ CO-PAY: ______
FAX: _________________________ Precert ___________
Secondary Insurance: _________________________ Phone: ________________
Address: ____
Contact: ________________ Cover Out-of-Network Services? _____________________
Policy Holder: _____________________ Policy Member Number: _________________
Employer: ____
Prior Author. Required? ______ Deductible: ______ Co-pay: ______
Fax: _________________________ precert
______MEDICAID Number (for P.T. and S.T.)____
Card Expiration Date: ____
______OTHER____

INSURANCE VERIFICATION IN NETWORK, OUT OF NETWORK, OUT OF NETWORK BENEFITS (circle one)
Date Verified: _________________ Source Person Name: ___________________________________
Co-pay and Deduct Info: ____OOPM: _______________
Number of visits allowed: ____ Will TX be covered under plan: ____ in network at ____ out of net at ___%
SPECIAL INSTRUCTIONS:
Tell Parent/Client to Bring:
______Physicians Prescription ______Insurance Card ______PMHx-Info
______Copies of Prev. Evals