Christian Psychological Center

3950 Central Avenue
Memphis, TN 38111
phone 901.458.6291, fax 901.323.4848
Please return this form via fax at 901.323.4848 or email to Intake@cpcmemphis.net

FOR OFFICE USE ONLY

Chart #:_____
Appt Date:_____
Appt Time: _____
Therapist: _____

PATIENT INTAKE AND VERIFICATION

Date: _____ Therapist requested: _____

Patient (legal name): _____ Referral Source: _____

Date of Birth: _____ Age: _____ Sex: _____

Parents (If patient is under 18) _____

Address: _____ City _____ State ____ Zip _____

Best Number to reach you: _____ Alternate Number: _____ Email: _____

What time of day is best for an appointment: _____

Presenting Problem: _____

_____

Legal/Custody Information **(if Client is under 18 and there are custody issues)**

□ Parents divorced, joint custody □ Parents divorced, mother custody □ Parents divorced, father custody □ Other Legal Issues _____

Who has physical custody? _____ Who makes medical decisions? _____

Primary Insurance

Insurance Co. Name _____ Mental Health/Provider Customer Service Phone # _____

Policy Holder's Name _____ Date of Birth _____

I.D.# _____ Group # _____ Employer: _____

Policy Holder's Address (if different from above): _____

Policy Holder's Relationship to patient: _____

Secondary Insurance

Insurance Co. Name _____ Mental Health/Customer Service Phone # _____

Policy Holder's Name _____ Date of Birth _____

I.D.# _____ Group # _____ Employer: _____

Policy Holder's Address (if different from above): _____

Policy Holder's Relationship to patient: _____

********** **SECTION BELOW FOR OFFICE USE ONLY** **********

Verification

Effective Date of Prim Coverage _____

Per _____ EAP Req? Y or N

M/H Ded _____ Portion Met _____

Co Pay _____ Co Ins _____ Visit Limit _____

Visits Used ____ Out pt pre-cert required? Y or N

Pre-cert Phone # _____

Auth Visit # _____ CPT _____

Dates _____ to _____

Auth # _____

Claim mailing address _____

_____

Effective Date of Secondary Coverage _____

Per _____ EAP Req? Y or N

M/H Ded _____ Portion Met _____

Co Pay _____ Co Ins _____ Visit Limit _____

Visits Used ____ Out pt pre-cert required? Y or N

Pre-cert Phone # _____

Auth Visit # _____ CPT _____

Dates _____ to _____

Auth # _____

Claim mailing address _____

_____