Christian Psychological Center

3950 Central Avenue Memphis, TN 38111
Phone 901.458.6291
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:____________

FIRST FORM

Date:_________________________ Therapist:___________________________
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/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 _________________________
____