INTENSIVE TREATMENT MODALITIES

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INTAKE INFORMATION FORM
(COMPLETE ON **ALL** NEW CLIENTS)

Today's Date

NAME:_____ SPOUSE/PARTNER_____
DOB_____ DOB_____
SS#_____ SS#_____
PHONE:
(H)_____(W)_____(CELL)_____
ADDRESS:_____
_____

PARENT NAME (if adolescent/child is the client) _____

Who referred you to Dr. Sager/Where did you learn about Dr. Sager's services:
_____

Problems or Concerns:_____
_____

INSURANCE: YES _____ NO_____ CASH? _____
COMPANY:_____
PHONE#: _____

INSURED'S NAME:_____
DOB:_____
EMPLOYER: _____
ID#_____ GROUP: _____

To be completed by ITM STAFF
APPOINTMENT DATE: _____ TIME: _____

PAPERWORK: FAXED MAILED EMAILED IN PERSON

AUTHORIZATION #:_____ EFF DATE:_____
COPAYMENT:_____ NUMBER OF VISITS:_____
DEDUCTIBLE AMOUNT?_____ DED MET? YES NO HOW MUCH MET?_____