ADDSOI
Testing Center

Adult Intake Form

Name: _____

Address: _____

_____

_____

Primary Phone: _____May we leave message? Yes/No

Alternate Phone: _____May we leave message? Yes/No

Email Address: _____

Preferred form of contact: Phone/Email

Birthdate: _____ Sex: ____ Handedness: _____

Marital Status: _____ College Graduate? _____

Occupation: _____ Full Time?_____

Are you adopted? _____ Are you a twin? _____

Children's names and ages: _____

_____

_____

_____

Other significant family members:

_____

_____

_____

Referred by: _____

Presenting problem (or reason you came here): _____

_____

_____

_____

Does anyone else in your family have this problem or similar behavior?

_____

_____

_____

Did you have any childhood surgery? _____

_____

Any other hospitalization? _____

_____

Do you currently have any medical conditions? _____

_____

Medications currently taken:	Name of doctor who prescribes:
_____	_____
_____	_____
_____	_____

Please list any known disabilities or school problems: _____

_____

_____

_____

Place a check if you suffer from any of the following. If a family member has the condition, please specify your relationship (e.g. sister, husband):

	Me	Family member
Seizures	____	_____
Depression	____	_____
Head injury	____	_____
Anxiety	____	_____
Tics or Spasms	____	_____
Thyroid problems	____	_____
Psychiatric Illness	____	_____
Asthma	____	_____
Diabetes	____	_____

Chemical dependency ____ _____
Have you been through a recovery program for chemical dependency? _____
How often do you smoke cigarettes? _____

How often do you drink alcohol? _____

How much coffee do you drink? _____

Do you use drugs recreationally? If so, what type and how often? _____

_____

Please list any unusual or traumatic events in your life, and the age at which they occurred:

_____

_____

_____

_____

_____

Have you or anyone in your family ever been in trouble with the law? _____

_____

Please use this space to tell us about anything else that is important to know about you:

_____

_____

_____

_____

_____

_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

71b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

Phone 310-546-8583
Fax 310-546-9068

ADD SOI Testing Center
Dr. Valerie Maxwell, Director

Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits, you have available, we ***require*** you to contact your insurance company at the phone number listed on your insurance card and ask the following information. **Failure to fill this form out *COMPLETELY* will disable us from billing your insurance provider for services rendered. It is your responsibility to pay for any outstanding balance.** Psychological Services and Therapy are *confidential* processes to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentiality may be compromised. Once you have completed this form, please email it with a copy of the front and back of your insurance card to drchristinaddsoi@hotmail.com.

Our office must receive this information BEFORE you will be scheduled for an assessment if you need authorization.

***Be sure you call or are transferred to the Mental Health department, *not* medical. When you reach a representative please state:**

"I AM CALLING TO CHECK MY OUTPATIENT MENTAL HEALTH BENEFITS."

1. **Is Dr. Valerie Maxwell a provider under my plan? Yes / No**
2. **Is my mental health insurance carved out to a different insurance provider? Yes / No**
   a. **(If #2 is Yes) What insurance covers mental health? _____**
3. **Is there a deductible for Psychological Testing or Counseling? (if none, enter "0"): $ _____**
   a. **(If #3 is *not* 0) Has the Deductible been met? Yes / No**
4. **What is my co-payment? _____**
5. **Do I need an authorization for mental health? Yes / No**
   a. **(If #5 is Yes) What is the authorization number? _____**
   b. **(If you have an authorization #) How many sessions are authorized to start? _____**
   c. **What is the start and end dates of the authorized sessions? Start_____ End_____**
6. **What is the MAXIMUM number of sessions I can use? _____**
7. **Do I need an authorization for Psychological Testing? Yes / No**
8. **Address to send Mental Health Claims:**
   (Often times different than address on card, please ask)
   Insurance provider:_____
   Address:_____
   _____

11. **Ph# Called:_____**
    Date of Call:_____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.

_____ _____
Signature Date

_____ _____
Print Name Client Name (Print)

Our office reserves the right to charge an administrative fee of $25 if the answers on this form are incomplete or incorrect.