

## New Patient Intake Form

***Please complete all sections. Failure to provide requested information will delay the processing of your intake form.***

### Demographic Information

Name (as appears on Insurance Card): \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is this also the billing address? \_\_\_\_\_

If **NO**, please provide the billing address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Contact Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Gender: \_\_\_\_\_ Primary Race \_\_\_\_\_

Marital Status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Were you referred by your Primary Care Physician? \_\_\_\_\_

**FOR MINORS ONLY:**

Name of Legal Guardian(s): \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

Parents Marital Status: \_\_\_\_\_

Legal Custodian of Minor Child: \_\_\_\_\_

***\* Each parents/guardian will be asked to sign authorization to treat prior to the commencement of care. Parents/Guardian(s) may be asked to provide proof of custody.***

Student Status: \_\_\_\_\_

Name of School: \_\_\_\_\_

**Scheduling Information**

Location:    Schenectady            Malta            Telehealth\*            Office & Telehealth

***\*Telehealth Appointments are conducted using audio/visual means as required by the patient's insurance policy. Please check to make sure that telehealth is a covered benefit under patient's policy.***

Scheduling:    Daytime            Evening            Weekend            No Preference

Appointment Type:    Counseling            Medication Management            Both

Please provide any additional scheduling requests:

**Financial Payment Information**

Name and address of the individual financially responsible for this patient's account:

Your Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Insurance Information**

***Please read each section carefully - Failure to provide requested information will delay the processing of your intake form AND may impact your financial responsibility with your assigned provider.***

**Primary Insurance Coverage**

Providers at Union locations **ARE NOT** Fee for Service Medicaid or Medicare providers. If a patient has Medicaid or Medicare as their **PRIMARY INSURANCE** the patient must pay their provider at the time of check-in and submit directly to Medicaid or Medicare for reimbursement. This includes minors that receive SSI and any individual receiving SSD.

Providers **DO ACCEPT** Medicaid and Medicare through managed care insurance companies.

Name of Primary Insurance Carrier: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Copay: \_\_\_\_\_

Provider Services Telephone Number (on back of card) \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Secondary Insurance Information**

If the patient has secondary insurance the information must be included on the intake form along with the primary insurance information. If Medicaid or Medicare are primary, the patient must pay their provider at the time of check-in and submit directly to Medicaid or Medicare for reimbursement. Once they receive their Medicaid or Medicare Explanation of Benefits they can submit directly to their secondary insurer or to our office for submission to their secondary insurer. Failure to provide this information at intake may impact your financial responsibility with your assigned provider as they may not be in-network with your secondary insurance company.

Name of Secondary Insurance Carrier: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Copay: \_\_\_\_\_

Provider Services Telephone Number (on back of card) \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**EAP Benefits**

If using EAP benefits all EAP information must be included on the intake form along with the patient's commercial insurance information listed under the primary insurance section. Failure to provide this information at intake may impact your financial responsibility with your assigned provider as they may not be in-network with your primary insurance company and EAP administrator

Name of EAP Administrator: \_\_\_\_\_

Provider Services Telephone Contact: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Effective Dates: \_\_\_\_\_ Number of Visits: \_\_\_\_\_

***\*Authorization Required Prior to First Appointment***

**Behavioral Health Background Information**

Have you been previously seen by a provider at Union Counseling?      YES      NO

    If YES: Name of Provider: \_\_\_\_\_

    Would you like to see the same provider again?      YES      NO

Have you seen a therapist in the past 6 months:      YES      NO

    If YES: Will you continue to see that therapist?      YES      NO

Were you referred to Union Counseling?      YES      NO

    If YES: Name of referring doctor: \_\_\_\_\_

    If YES, referred for:      Counseling      Medication Management      Both

Please answer the following screening questions for the **PATIENT**:

Do you have thoughts of hurting yourself:      YES      NO

Do you have thoughts of hurting others?      YES      NO

Have you been hospitalized for psychiatric reasons?      YES      NO

    If YES: Date of last hospitalization: \_\_\_\_\_

Do you currently consume alcohol?      YES      NO

    If YES: How much and how often: \_\_\_\_\_

    If YES: Are you or someone in your life concerned?      YES      NO

Do you currently use drugs?      YES      NO

    If YES: Drug(s) abused: \_\_\_\_\_

    If YES: How much and how often: \_\_\_\_\_

    If YES: Are you or someone in your life concerned?      YES      NO

Do you have current/past arrests, probation or legal issues?      YES      NO

    If YES, please provide details:

Are there any court orders in place for treatment?      YES      NO

If YES, please provide details:

**Current Medications** – Please list all medications currently prescribed to patient:

Medication	Dosage	Prescribing Physician

In your own words, please explain the reason you are seeking counseling/medication management: