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 an 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 are 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:
