Initial Intake Form

Center for Authentic Living, Inc.
Park Ridge

Patient Information

Patient's Name: _____

Patient's Birthdate: _____

Address: _____

City: _____ Zip_____

Home Phone: _____

Cell: _____

Email: _____

Referred by: _____

Insured Information (if different than patient)

Insured Name: _____

Insured's Birthdate: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____

Cell: _____

Email: _____

Insured Employer: _____

Insurance Company Information

Name of Insurance Company and Plan: _____

Insured ID # (Include Alpha Prefix): _____ Insured Group Policy #: _____

Credit Card Use: (Circle) Visa Mastercard AMEX Zip Code:_____

Card #_____ Expiration Date: _____ Security Code (3 or 4 digits): _____

Cardholder's signature authorizing charges on this account: _____

Note: Missed sessions will be charged the full fee on the credit card.

Office Use Only

Yearly Deductible: $_____

Co-pay for Outpatient Mental Health: $_____ Maximum visits per year:_____

Authorization required? Number to call for pre-authorization: _____

CPT_____ DX_____ MEDS_____