PARADIGM THERAPY PARTNERS LLC

Patient Intake Form

Today's Date: _____ Appointment Date: _____ Time: _____ ☐AM ☐ PM

Previous Patient: ☐Yes ☐No

Patient Name (Last, First, Middle) _____DOB ___/____/_____

Social Security: ____/_____/_____ Sex: ☐Male ☐Female

Home Address: _____

Home Ph _____ Wk Ph_____ Cell Ph _____

Email Address: _____ Employer Name: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other

Insurance Information

Type of Plan: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid

Primary Insurance: _____ Pol# _____ Grp#_____

Subscriber Name: _____ DOB: ___/___/___ SSN: _____

Eff Date: ____/____/_____ Copay/Coinsurance _____ Deductible: _____ Met? ☐ Yes ☐ No Amount Met:

Referring Physician Name: _____ Primary Care Physician: _____

Office#/ Fax# _____ Office#/Fax# _____

---------- **Additional Information to be completed by Paradigm Therapy Partners**----------

Ins Main Number: _____ Auth Phone: _____ Ext: _____

Secondary Insurance: _____ Pol # _____ Grp# _____

Subscriber Name: _____ DOB:___/___/___ SSN: _____

Eff Date: ____/____/____ Copay/Coinsurance _____ Deduct: _____ Met? Y/N Amount Met: _____

Max Visits: _____(Per condition/Per Cal yr) PCP Ref Needed: Y/N Auth-Cart Needed: Y/N

Auth/Per-Cert# _____ #Visits _____ Claim Address: _____

Rep. Name: _____ Confirmation Number: _____

Insurance Main Number: _____Authorization Phone: _____ Ext: _____

Max Visits: _____ (Per condition/Per cal. Yr) PCP Ref Needed: Y/N Auth-Cert Needed: Y/N

Auth/Pre-Cert# _____#Visits _____ Claim Address: _____

Rep. Name: _____Confirmation Number: _____

.....Partnering for your Success.....

4483A Forbes Blvd
Lanham, MD 20706

1526 Howard Rd, SE
Washington, DC 20020

Office: (240) 479-6769 Fax: (888) 242-8040