Walpole Behavioral Healthcare LLC.

10 Common St. #64 Walpole, MA 02081 Phone (508) 668-6053 Fax (508) 422-7297

Initial Intake Form

Today's Date: _____

Patient Name: _____

Last First Middle Initial

Patient Date of Birth:_____ Patient Age: _____

Address:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell(Self/Parent):_____

Email address:_____

Emergency Contact: _____ Phone #: _____

Primary Care Provider: _____ Phone #: _____

PCP Address: _____

Current Medications: _____

Patient's Insurance Company: _____ Card #: _____

Copay for Mental Health services (please call insurance company if amount not listed on card):$_____

Subscriber Name: _____ Subscriber's DOB: _____

Subscriber's Relation to Patient: _____

Subscriber's Address if different from patient's: _____

Subscriber's Employer: _____

Auth #(Only for Tufts or EAP plans): _____ # of Sessions: _____

If there is secondary insurance or EAP, Ins. Co. Name: _____

Card Number: _____

I hereby authorize by my signature that:
1.____ (Y/N) My therapist may contact and coordinate my treatment with my Primary Care Physician.
2.____ (Y/N) As insured or authorized person, I hereby assign any insurance benefits to Walpole Behavioral Healthcare and authorize them to furnish any necessary information needed to submit and process claims to my insurance company.
Patient/Legal Guardian Signature: _____ Date: _____