Center for Personal Growth
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PLEASE FILL IN ONLY TOP PORTION:

Client name: ____ **Reason for visit:** **Therapy** **Testing**

Client DOB: ________________ **Mother/Father's name:** _______________________________
(If adolescent)

Client address: ____
Street *City* *Zip*

Client *preferred* phone: ____ **cell / home / work**

✦Can we text this number for appointment Reminders? **Y** **N**

Policyholder name: ______________________________ Policyholder DOB: _________________

Relationship to client: ______________________________ Policyholder SS#: _________________

Policyholder address: ____

Insurance Company Name & ID#: ____
Group # ___________________________

Claims mailing address: ____

____

Insurance Company phone: ____

ELIGIBILITY / BENEFITS

Effective date: ______________ Plan type: PPO HMO Other

Individual Deductible: ____________________ Family Deductible: ___________________

Is MENTAL HEALTH deductible ***separate*** from REGULAR deductible? Y N

Amount already met: ____________________ Amount already met: ___________________

Individual OOP Max: ____________________ Family OOP Max: ___________________

Amount already met: ____________________ Amount already met: ___________________

Office Visit copay: ____________________ **Co-insurance:** __________________________

Maximum # of visits: ________ per calendar year **Visits already used:** ___________________

90834 YES NO 90837 YES NO **Psych 96101 YES NO** **Neuro96118 YES NO**
90846 YES NO 90847 YES NO **Group Allowed? 90853 Y N** **EAP? YES NO**
REF#_____________________ **Name:**_____________ **Date:** _____________