Appointment Date & Time: \_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_ Fiscal: Y or N

Client ID: Insurance Type: Date Verified:

Co-Pay: Amount: $ Deductible: \_\_\_\_\_\_\_\_\_\_ Amount $ \_\_\_\_\_\_\_\_\_\_ Initials:

 

20231 Paint Boulevard 850 Leonard Street

Shippenville, PA 16254 Clearfield, PA 16830

(814) 226-1159 (814) 205-4004

Fax (814) 227-2876 Fax (814) 205-4013

**BATTERERS’ INTERVENTION SERVICES**

Today’s Date:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral/presenting problem:

Criminal charges pending:

Probation or parole officer:

Max date:

Court ordered treatment?:

Is there is a protection from abuse order against client?: \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If yes, please explain:

Does the referred have Medical Assistance?: \_\_\_\_ Yes \_\_\_\_ No

MA Number: County where issued:

Does the referred have any other insurance coverage?: \_\_\_\_ Yes \_\_\_\_ No

If so, list the name of insurance and numbers:

Who is responsible for the payment of services?(client, agency, etc.):

Is the agency paying for services if there is no insurance coverage? \_\_\_\_ Yes \_\_\_\_ No

Referral Source Information:

Name:

Agency: Phone:

Address: Fax: