dynamic fusion
COUNSELING
& CONSULTING

710 E. Ogden Ave. Suite 645, Naperville, IL

Insurance Intake Form

Demographic Information

First Name: ____
Middle Initial: ____
Last Name: ____
Date of Birth: ____
Social Security Number: ____
Sex: M F
Marital Status:____
Address: ____
City:____
State: ____
Zip Code: ____
Phone Number: ____
Email Address:____
Referring Physician:____
Referring Physician Phone Number: ______________________________________

Insurance Information

Primary Insurance Company: ____
Subscriber ID # (including letters): _______________________________________
Group Number: ____
Secondary Insurance Company: ____
Subscriber ID # (including letters): _______________________________________
Group Number: ____
Insurance Policyholder Full Name: ______________________________________
Insurance Policyholder Date of Birth: ____________________________________
Insurance Policyholder Address: ____
Insurance Policyholder Relationship: Self Spouse Child Other
Insurance Policyholder Social Security Number: _____________________________
Insurance Policyholder Sex: M F

** Note: All information is required.*

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Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize the provider's billing company, TheraThink, to file all medical claims with the information on this form. I authorize payment of medical benefits to the provider for services rendered.

Patient Signature: ______________________________________ Date: __________
Guardian Signature (if minor): ______________________________ Date: __________
Patient Full Name: ____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: ______________________________________ Date: __________
Guardian Signature (if minor): _____________________________ Date: __________
Patient Full Name: ____

** Note: All signatures are required.*