VERIFICATION OF BENEFITS FORM

Appointment date/Time: _____

Information from Client:

Minor ☐

Name: _____

Address: _____

_____

_____

DOB: _____

Soc. Sec.#: _____

Home Phone: _____

Cell Phone: _____

Insurance/EAP Co: _____

Policyholder name: _____

Policyholder Soc. Sec.#: _____

Policyholder DOB: _____

Policy ID#: _____

Group ID#: _____

Employer: _____

Eff. Date: _____

Mental Health Phone #: _____

Information from Insurance Company:

Are there out patient mental health benefits? ☐ Yes ☐ No ☐ NA
Are there out patient substance abuse benefits? ☐ Yes ☐ No ☐ NA
Is provider in network? ☐ Yes ☐ No ☐ NA
Do they have out of network benefits? ☐ Yes ☐ No ☐ NA

What are the out of network benefits? _____

Co-pay/Co-insurance (circle) **Amount** **$** _____

Deductible Amount **$** _____

Has it been met? ☐ Yes ☐ No ☐ NA

Are *Authorizations* required for a:
Intake ☐ Yes ☐ No ☐ NA
Ongoing therapy ☐ Yes ☐ No ☐ NA

When? _____

Authorization Number #
How many visits are approved? # _____

Authorization Start Date: _____
Authorization End Date: _____

How many visits per year allowed? # _____
NOTES:

Lisa Walton, LISW

2525 N. Ankeny Blvd. Suite 113 • Ankeny, IA 50021
515-289-9136 515-289-9139 (Fax)

GENERAL INTAKE INFORMATION

REFERRED By: _____

Reason for Referral: _____

Have you received mental health treatment before? ☐ Yes ☐ No
If so, when and where_____

Do you use: ☐ Tobacco? ☐ Alcohol? ☐ Non-prescription drugs?

Have you been treated for alcohol/drug problems before? ☐ Yes ☐ No
If so, when and where_____

Please check any of the following that you have experienced recently:

☐ Depression	☐ Anxiety	☐ Sleep disturbance	☐ Suicidal thoughts
☐ Panic attacks	☐ Paranoia	☐ Appetite problems	☐ Stealing
☐ Compulsive behaviors	☐ Weight loss/gain	☐ Racing thoughts	☐ High Energy
☐ Low energy	☐ Poor attention	☐ Social withdrawal	☐ Anger/irritability
☐ Distractibility	☐ Aggression	☐ Poor concentration	☐ Blackouts
☐ Hyperactivity	☐ Memory problems	☐ Other(s)_____	

FAMILY/HOME INFORMATION: List people living in the home:

Name	Age	Relationship to client

MEDICAL/HEALTH INFORMATION

Do you have any current or ongoing medical problems? ☐ Yes ☐ No
If so, please explain: _____

Who is your primary doctor/medical provider?

_____ _____ _____
Name *City* *Phone number*

What medications do you take? Include non-prescription, herbal medicines and supplements.

Medicine	Dose	Frequency	Who prescribes

Please list any allergies, including medication allergies/sensitivities:

_____