Behavioral Solutions, LLC
(816) 984-8290
Fax: (816) 439-6169

Date: _____

PATIENT INTAKE

Reason for Visit:

☐ Therapy/ Counseling/ Other _____

☐ Psychological Assessment _____

☐ Other _____

Patient Information:

Patient Name: _____

Address: _____

City: _____ Zip: _____ State: _____

Date of Birth: _____ School:_____

Parent / Guardian Information:

Parent/ Guardian Name (S): _____

Address (If different): _____

Email: _____ Cell Phone: _____

Home Phone: _____ Are you the legal guardian? □Yes □No

Martial/ Legal Status: _____

Emergency Contact Name & Phone: _____

Insurance Information:

Primary Insurance Carrier: _____ Policy Holder Name: _____

DOB:_____ Employer: _____

Member ID # _____ Group # _____

Secondary Insurance? □Yes □No

Behavioral Solutions, LLC
(816) 984-8290
Fax: (816) 439-6169 Date: _____

I authorize payment of medical benefits to the undersigned physician or supplier (Behavioral Solutions, LLC or Family First Center for Autism) for mental health services:

Printed Name: _____ Signature: _____ Date: _____

I authorize the release of any medical or other information necessary to process this claim:

Printed Name: _____ Signature: _____ Date: _____

Confidentiality:
I understand that I may have access to private patient information while visiting Behavioral Solutions, which operates within the Family First Center for Autism building. I agree to keep all patient information confidential and will not discuss, share, or disclose it to anyone. I understand that HIPAA and state laws protect this information.

Printed Name: _____ Signature: _____ Date: _____

Video & Audio Acknowledgement:
I understand and acknowledge that Family First Center for Autism uses video and audio surveillance for office security and safety purposes. Direct sessions with Behavioral Solutions psychologists will **not** be video monitored. I understand that Behavioral Solutions cannot control or limit Family First's audio or video surveillance within the building.I understand that my privacy and HIPAA rights will be respected and protected while I am in the building. Behavioral Solutions will maintain the confidentiality of my information in accordance with applicable privacy laws.

Printed Name: _____ Signature: _____ Date: _____

Office Use Only:
Co-Pay: _____ Deductible: _____ Coinsurance:_____

Pre Certification: Yes No ABA Benefits: Yes No Auth#: _____