TERRAP ANXIETY AND PHOBIA CARE

COGNITIVE AND BEHAVORIAL HEALTH ASSOCIATES

A division of Julian M. Herskowitz, PhD, Psychologist, P.C.

www.anxietyandpanic.com

INTAKE FORM

Patient name: _____ Date of birth: _____ Male ☐ Female ☐

Patient address: _____ City: _____ State_____ Zip _____

Home #: _____ Cell #: _____ Email: _____

Policy Holder's name: _____ Date of birth: _____ S.S #: _____

Home #: _____ Cell #: _____ Email: _____

Is it Ok to contact you by email? ☐ yes ☐ No

Relation to Policy Holder: ☐ Self ☐ Daughter ☐ Son ☐ Spouse ☐ Other _____

Employer Name: _____ Employer Address: _____

It is important to contact your insurance and find out:

Do you have out-of-network benefits? ☐ yes ☐ No **Is Pre-authorization required?** ☐ yes ☐ No

Do you have a deductible? ☐ yes ☐ No **How much is your deductible?** _____

When does your deductible start? _____

Primary Insurance Name: _____ Plan Name: _____

Insurance ID #: _____ Group #: _____ Payer ID: _____

Provider Tel. # (on back of card): _____

Claim address: _____ City: _____ State_____ Zip _____

Secondary Insurance Name: _____ Plan Name: _____

Insurance ID #: _____ Group #: _____ Payer ID: _____

Provider Tel. # (on back of card): _____

Claim address: _____ City: _____ State_____ Zip _____

Emergency contact name, relation and phone #: _____

For office use only:

Assigned Therapist Name: _____ **Diagnosis**: _____