EBS CI
CHILDREN'S INSTITUTE
Research • Training • Treatment

Patient Intake and Financial Form

Patient Name: ______________________________ DOB: ________________

Home Address: ____

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Home Phone: ______________________ Cell Phone: ______________________

E-mail address: ____

Mother's Name: _________________________ DOB: __________

Father's Name: _________________________ DOB: __________

Pediatrician/Doctor:

____

Clinic Name:

____

Phone: _______________________ Fax: _______________________

Child's Diagnosis (if known) and Year:

____

Reason for Referral:

____

INSURANCE INFORMATION

Primary Insurance: ________________________________ Phone: __________________

Mailing Address for claims:____-

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Subscriber's Name: _____________________Subscriber's DOB: _____________________

Policy ID #: ________________________________Group #: _________________________

Employer/Group Name:____

Medicaid: □ Yes □ No

Medicaid #: ___________________________________

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand if additional service time is requested on my part above what is recommended, I agree to pay the current private pay rate for any additional service time. I understand that if my insurance or Medicaid information changes at any time, it is my responsibility to notify EBS Children's Institute of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance/Medicaid denies services due to lack of authorization and/or verification of benefits.

Signature: ____ Date: ___________

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Name of Person Completing This Form

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Relationship to Patient