Pitts & Associates Child Intake Form

Child's Name (listed on insurance)_____

Child is called: _____ Date of Birth: _____

Social Security Number:_____ Gender:_____

Street Address:_____

City: _____ State:_____ Zip:_____

Phone #1:_____ name listed under? _____
(#1 used for appt reminders)
Phone #2:_____ name listed under? _____

Email Address : _____

Person Responsible for Payment:_____

Street Address:_____

City: _____ State:_____ Zip:_____

Phone #1:_____ Phone #2:_____ Phone #3:_____

Social Security Number:_____ Employed By: _____

PRIMARY_____ SECONDARY_____

Subscriber's Name: _____ Subscriber's Name: _____

Birth date of Subscriber: _____ Birth date of Subscriber:_____

Relation to patient: _____ Relation to patient: _____

Employer: _____ Employer: _____

Contract Number:_____ Contract Number:_____

PLEASE LET US KNOW TODAY if you are using your EAP for your initial visits. Yes___ No ___

If Yes, name & auth no. _____

This child lives with: _____ Relationship to Child_____

(If applicable, child is in legal custody of: _____ Full? ____ Joint? _____

Father's name: _____Mother's name: _____

Stepfather's name: _____Stepmother's name: _____

I understand that, as a courtesy to me, Pitts & Associates files my insurance. I understand that Pitts & Associates is NOT responsible for keeping up with my insurance company's deductible, co-pays and/or the number of visits authorized by my Insurance. I also understand that my insurance company is NOT responsible for my bill, but that I am. If my insurance company does not pay in a timely manner, I will pay the bill in full.

Signature _____Date:_____
Responsible Party (typed name constitutes signature)

I (We), the undersigned, hereby agree to pay all amounts and charges for services rendered by Pitts & Associates, Inc., no later than 30 days of the rendering of said services unless other specific arrangements are made. In the event of default of payment of said services, I (we) waive as to this debt all rights of exemptions under the constitution and laws of the State of Alabama, or of any other state, as to personal property, and agree to pay all costs of collection or securing or attempting to collect or secure said indebtedness, including a reasonable attorney's fee.
I ALSO UNDERSTAND THAT UNLESS A CANCELLATION OF AN APPOINTMENT IS MADE 24 HOURS IN ADVANCE OF SAID APPOINTMENT, I WILL BE SUBJECT TO CHARGE FOR THE TIME RESERVED

Signature _____Date:_____
Responsible Party (typed name constitutes signature)

I authorize the release of any medical information necessary to process this claim and request payment to Pitts & Associates, Inc.

Signature _____Date:_____
Responsible Party (typed name constitutes signature)

Insurance Worksheet (for your use only)

For your convenience, insurance claims are filed by our office staff following your visit. You may be responsible for a co-pay or deductible amount at the time of service.

If you plan to use insurance to help pay for services at Pitts & Associates, you will need to verify your coverage for mental health services before the first session. We have included a form at the end of this document to assist you in this process. Contact information for your insurance provider is usually located on the reverse side of your insurance card.

The following insurance companies are accepted by one or more of our clinicians. Please contact your insurance provider to verify your coverage.

Blue Cross Blue Shield of Alabama
Federal Blue Cross Blue Shield
Medicaid
American Behavioral
Behavioral Health Systems
TriCare
Out of State Blue Cross Blue Shield
Medicare
United Behavioral Health/OPTUM
Aetna
Cigna

Questions to ask your insurance company before your first visit with us:

What are my outpatient mental health benefits?_____
_____
_____

What is my yearly deductible? _____ Has it been met yet? _____

What is the renewal date for my benefits? _____

What is my co-pay once the deductible has been met? _____

Is authorization required? If so, what is my authorization number? _____

How many visits does this authorize? _____

What needs to be done to request additional visits? (Clinician send in treatment plan?)_____

Where? fax number or address _____

Where are insurance claims mailed? _____
_____
_____

PLEASE UNDERSTAND. Your insurance will NOT cover any charges for missed appointments or late cancellations (less than 24 hours advance notice).