BLUE MOUNTAIN PSYCHOLOGY, PLLC

**Please complete as much information as possible including a phone number for the insurance company. Thank you.**

| | | |
|---|---|---|
| Today's Date: ____/____/20____ | Patient Name: _____ First Last Middle | Patient's Date of Birth (DOB): ____/____/_____ |
| Patient Address: | | **Email:** |
| Patient's home phone: ( ) | Patient's work phone: ( ) | Patient's cell phone: ( ) |
| ☐Male ☐Female ☐Other _____ | Patient's SSN: ____-___-_____ | Previous patient? ☐Yes ☐No Dates: _____ |
| Race: | Ethnicity: | |
| **Referral reason:** | | |
| Name of referee: | Referee phone number: ( ) | Referee fax number: ( ) |
| Referee NPI#: | Referee address: | |
| Primary Care Physician (PCP): | PCP phone number: ( ) | PCP address: |
| **Primary** insurance carrier: | Insurance phone#: ( ) | Claims mailing address: |
| Contract #: | Group#: | |
| Subscriber name: _____ First Last Middle | Subscriber's Date of Birth: ___/___/_____ | Employer: |
| Date verified (**Staff only**): ____/____/20____ | Contact person: | Call notes: |
| **Secondary** insurance (inc. auto): | Insurance phone#: ( ) | Claims mailing address: |
| Contract #: | Group#: | |
| Subscriber name (if different): _____ First Last Middle | Subscriber's Date of Birth: _____/_____/_____ | Employer: |
| Date verified (**Staff only**): ____/____/20____ | Contact person: | Call notes: |
| | | Authorization #: |

**Services Provided (BMNA Staff only)**

ICD-9: _____ _____ _____ _____

DSM-IV-TR: Axis I _____ Axis II _____ Axis III _____ Axis IV _____ Axis V ___

☐90791 ____/____/20__ ☐90832 ____/____/20__ ☐90834 ____/____/20__

☐96101 ____/____/20__ ☐96118 ____/____/20__ ☐_____ ____/____/20__

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