LOOKING UP COUNSELING, PLLC 200712980A

BILLING INITIATION FORM

(Note: This form is used to initiate billing.)

Intake Date: _____ Clinic: _____ Therapist: _____
Case Manager: _____

Client name, exactly as it is shown on his or her Medicaid card:

Last Name: _____ First Name: _____ MI ____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

EMAIL: (for a digital handbook)_____

Medicaid Number: _____ Phone Number: _____

Primary Diagnosis *(from DMS-V)*: _____

Does this person qualify for rehab services? YES NO Qualifier: IEP Testing Disability Inpatient

Are you interested in having a Psychological Assessment (Testing) completed? Yes No

EMERGENCY CONTACT INFORMATION

****For minors: Please list someone other than child's primary guardian. ****

Name: _____ ____ Relationship: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Special Instructions for Contact: _____

Name of Pharmacy Used: _____ City: _____