Innovative IPS Psychiatric Solutions

FACE SHEET

DATE_____ TIME of ARRIVAL: _____

Please Complete ALL information

1. Patient Demographics						
Patient Last Name:		First:			Middle:	
Sex: ()M ()F	DOB:	Age:	Marital Status: ()S ()W ()M ()D ()Separated	Ethnic Origin: ()Caucasian ()African-American ()American Indian ()Hispanic ()Asian ()Other		Religion:
Address:		Apt#:	City:	State/Zip:		
Home Phone:	**Cell Phone:**	Social Security #:		Driver's License/ State (if applicable):		
Employer Name:		Occupation:	Length of Employment:		Employer Phone:	
Highest Level of Education (current grade level):			Degree Obtained:			
Primary Care Physician Name:		Address:	City:	Phone Number/Fax Number:		
2. Guarantor/Legal Guardian/Parent of Minor:						
Last Name:		First:	Sex: ()M ()F	DOB:	Relation:	
Cell Phone:		Social Security#:	Occupation:			
Address:		Apt #:	City:	State/Zip:		
Employer Name:			Length of Employment:	Employer Phone:		
3. Primary Insurance Information:						
Name of Insurance:			Insurance Phone:			
Policy/Hic#:		Social Security #:	Group Name:		Group#:	
Insured's Last Name:	First:	Middle Initial:	Sex: () M ()F	Relation:	DOB:	
Employer Name:	Occupation:	Length of Employment:		Employer Phone:		
Employer Address:	Suite#:	City:	State/Zip:			
4. Secondary Insurance: ( )None-Go to Section 5 ( )Yes - Complete Section 4						
Name of Insurance:			Insurance Phone:			
Policy/Hic#:		Social Security #:	Group Name:		Group#:	
Insured's Last Name:	First:	Middle Initial:	Sex: () M ()F	Relation:	DOB:	
5. Please describe briefly the problem that brought you here today.						

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6. Emergency Contact:	
Emergency Contact #1:	Relationship:
Address:: City, State/Zip:	Best Contact Number:
For minors, if parents are not together and patient has contact with non-custodial parent, please provide parent's name and include status of custody arrangement.	Relationship to Patient:
2nd Parent Name:	Status of Custody Arrangement:
Address: City, State/Zip:	Best Contact Number:

7. Previous Mental Health or Chemical Dependency Hospitalizations:	
Last 12 months: ( )Yes ( ) No	Last 6 months: ( )Yes ( )No
Where:	Where:
When:	When:
Why:	Why:
How long:	How long:

8. How did you hear of Innovative Psychiatric Solutions?
( )Mental Health Professional ( )Legal/Judicial ( )Psychiatrist ( )Clergy/Church ( )Family/Friend ( )Internet ( )Insurance Company ( ) A Previous Patient ( )Advertisement ( )Organization ( )Other (Please Specify below)

9. Specific names of individuals/organizations who referred you:	
Name:	Title:
Address:	City:
State:	Zip:
Telephone:	**Permission to contact: ( )Yes ( )No**

10. If patient is a minor, provide information on patient's school.	**Homeroom/Primary Teacher Name**:
School Name/District:	City:
Address:	State/Zip:
Telephone:	**Permission to contact: ( )Yes ( )No**

Purpose of disclosure: To identify persons supporting and using services; notification of admission, discharge, and aftercare plans.

All requested information must be completed for insurance claims to be correctly processed. Exclusion of insurance policy information may result in an insurance denial in which you will be totally responsible for your bill. The person who signs consent is the Guarantor/responsible party for this bill.

I authorize the release of any medical or other information necessary to process this claim to my insurance company. This may also include case managers with your insurance company. I also authorize payment of medical benefits to Innovative Psychiatric Solutions, Inc., for services rendered to me.

Signature Date *Revised 7/12/2013*