SIMPLE OFFICE SOLUTIONS
NEW PATIENT INTAKE FORM

S.O.S is the billing service center for your healthcare provider. The following information is necessary to determine your health insurance benefits for services rendered by your provider.

Please complete this form and send it via email to directly to S.O.S. at **simpleofficesolutions1@gmail.com**. Please attach a copy of your insurance card.

We will contact you with your insurance benefit details so you will know what to expect at the time of service. We will inform you of any co-pay and/or deductible amounts that must be paid at the time of service. If you have questions related to this form or your insurance benefits please contact Gena Miller at: 240-676-1604.

Date:_____/_____/_____ **Appointment Date:**_____/_____/_____

Name of Therapist:_____

Patient Name:_____ **MALE** ___ **FEMALE**___

DOB:_____/_____/_____ **Primary Ph:**_____/_____ **Alt Ph:**_____/_____

Address:_____
Number Street City State Zip

Primary Insurance Carrier:

Name:_____

ID #:_____

Grp #:_____

Plan:_____

Policy Holder:_____

Relationship:_____ **DOB:** _____

Secondary Insurance Carrier:

Name:_____

ID #:_____

Grp #:_____

Plan:_____

Policy Holder:_____

Relationship:_____ **DOB:** _____

OFFICE USE ONLY:

CO-PAY:_____ DEDUCTIBLE:_____/_____

EAP: Y / N AUTH: Y / N #_____ # OF SESSIONS:_____