Christian Psychological Center

3950 Central Avenue Memphis, TN 38111 Phone: 901.458.6291

Please return this form via fax at 901.323.4848 or email to intake@cpcmemphis.net

FOR OFFICE USE ONLY

Chart #:_____

Appt. Date:_____

Appt Time:_____

Therapist:_____

FIRST FORM

Today's Date:_____ Preferred Therapist:_____

Patient (full legal name):_____

Marital Status: □ Single □ Married □ Divorced □ Widow Date of Birth: _____ Age:_____

Sex: _____ Parents Names (If patient is under 18):_____

Address: _____ Apt #: _____ City:_____ State:____ Zip:_____

Best number to reach you: _____ May we leave a message? □ Yes □ No

Would you like appointment reminders by text message? □ Yes □ No

Email:_____

What time of day is best for an appointment: ____:_____ □ AM □ PM

Presenting Problem:_____

_____

How did you hear about us and/or referral source: _____

Legal/Custody Information

Is this appointment court ordered? □ Yes □ No

(if client is under 18 and there are custody issues): □ Joint Custody □ Mother Custody □ Fathers Custody □ Other

Details if needed: _____

Who has physical custody? _____ Who makes medical decisions? _____

INSURANCE INFORMATION

Note: Dr. Hart, Dr. Neal, Dr. Brent Stenberg, David Stenberg, Lori Newsom accept a limited list of insurances.

Are you willing to Self pay? ☐ Yes ☐ No

Primary Insurance

Insurance Co. Name: _____ Mental Health/Customer Service Phone #: _____

Policy Holder's Name: _____ Date of Birth:_____

I.D.#:_____ Group #: _____ Employer: _____

Policy Holder's Address (if different from above): _____

Policy Holder's Relationship to patient: □ Self □ Parent □ Spouse □ Other (Specify): _____

Secondary Insurance

Insurance Co. Name: _____ Mental Health/Customer Service Phone #: _____

Policy Holder's Name: _____ Date of Birth:_____

I.D.#:_____ Group #: _____ Employer: _____

Policy Holder's Address (if different from above): _____

Policy Holder's Relationship to patient: □ Self □ Parent □ Spouse □ Other (Specify): _____

************************************SECTION BELOW FOR OFFICE USE ONLY************************************

Verification

Effective Date: _____ M/H Deductible: $_____ Portion Met:_____ Co Pay: $_____

Co. Insurance: _____ Visit Limit: _____ Visits Used: _____

Claims mailing Address: _____City: _____ State: ____Zip: _____