

TheITMGroup

INTENSIVE TREATMENT MODALITIES

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INTAKE INFORMATION FORM (COMPLETE ON ALL NEW CLIENTS)

Today's Date _____

NAME: _____ SPOUSE/PARTNER _____

DOB _____ DOB _____

SS# _____ SS# _____

PHONE: _____

(H) _____ (W) _____ (CELL) _____

ADDRESS: _____

PARENT NAME (if adolescent/child is the client) _____

Who referred you to Dr. Sager/Where did you learn about Dr. Sager's services:

Problems or Concerns: _____

INSURANCE: YES _____ NO _____ CASH? _____

COMPANY: _____

PHONE#: _____

INSURED'S NAME: _____

DOB: _____

EMPLOYER: _____

ID# _____ GROUP: _____

To be completed by ITM STAFF

APPOINTMENT DATE: _____ TIME: _____

PAPERWORK: FAXED MAILED EMAILED IN PERSON

AUTHORIZATION #: _____ EFF DATE: _____

COPAYMENT: _____ NUMBER OF VISITS: _____

DEDUCTIBLE AMOUNT? _____ DED MET? YES NO HOW MUCH

MET? _____