

# CLINICIAN INFORMATION INTAKE

**IT IS IMPORTANT THAT WE HAVE ALL YOUR INFORMATION LISTED IN ONE PLACE FOR YOUR CLIENT FILE.**

PLEASE FAX OR EMAIL YOUR COMPLETED QUESTIONNAIRE FORM TO THE REVITALIZED THERAPIST

 **FAX:****816.301.6258** **EMAIL:** **support@revitalizedtherapist.com**

# Please Only Complete Information Relevant to The Services We Are Providing You With.

# PROVIDER DEMOGRAPHICS:

1. NAME:
2. BUSINESS NAME:
3. LIST YOUR PRACTICE ADDRESS:
4. LIST YOUR PRACTICE PHONE NUMBER:
5. LIST YOUR PERSONAL CELL PHONE NUMBER:
6. PRIVATE PRACTICE WEBSITE:
7. LIST YOUR FAX#:
8. Office Hours:
9. Phone System Used (phone.com, grasshopper):

# PRACTICE POLICIES:

* AGES OF THE CLIENTS YOU WORK WITH:
* WHAT PRESENTING ISSUES DO YOU TREAT?
* WHAT GROUPS DO YOU FACILITATE?
* WHAT TRAININGS OR CERTIFICATIONS HAVE YOU COMPLETED?
* WHAT DO YOU WANT YOUR CALLERS TO KNOW ABOUT YOU AND YOUR SPECIALIZATIONS?
* LIST YOUR CANCELLATION POLICY FOR INDIVIDUAL SESSIONS:
* LIST YOUR CANCELLATION POLICY FOR GROUPS:
* LIST YOUR FEE(S) FOR SERVICE(S):
* ARE YOU SET UP TO RECEIVE ELECTRONIC EOBS IN YOUR EHR?
* DO YOU WANT US TO OBTAIN EMAIL INFORMATION FROM CALLERS FOR YOUR EMAIL NEWSLETTER?
* LIST YOUR IDEAL CLIENT:
* LIST CLIENTS THAT ARE NOT APPROPRIATE FOR THE SERVICES YOU PROVIDE/NON-IDEAL CLIENTS:

# Information Needed to Set Up Your EHR

* LIST YOUR TAX ID:
* LIST YOUR CREDENTIALS:
* LIST YOUR NPI:
* LIST YOUR GROUP NPI:

# Information Needed to Access Your EHR

### EHR:

* WEBSITE:
* LOGIN:
* PASSWORD:

# Frequently Used Passwords:

**EMAIL:**

LOGIN:

PASSWORD:

**PHONE SYSTEM:**

ACCOUNT NAME:

VOICEMAIL PASSWORD:

USERNAME:

EXTENSION:

### SOCIAL MEDIA PASSWORDS

ACCOUNT:

PASSWORD:

USERNAME:

### SOCIAL MEDIA PASSWORDS

ACCOUNT:

PASSWORD:

USERNAME:

### SOCIAL MEDIA PASSWORDS

ACCOUNT:

PASSWORD:

USERNAME:

### SOCIAL MEDIA PASSWORDS

ACCOUNT:

PASSWORD:

USERNAME:

### SOCIAL MEDIA PASSWORDS

ACCOUNT:

PASSWORD:

USERNAME:

**WEBSITE PASSWORDS**

LOGIN URL:

PASSWORD:

USERNAME:

**WEBSITE PASSWORDS**

LOGIN URL:

PASSWORD:

USERNAME:

***MISCELLANEOUS* ACCOUNT/APPS/PROGRAMS PASSWORDS**

ACCOUNT:

PASSWORD:

USERNAME:

PURPOSE OF THIS ACCOUNT:

ACCOUNT:

PASSWORD:

USERNAME:

PURPOSE OF THIS ACCOUNT:

ACCOUNT:

PASSWORD:

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PURPOSE OF THIS ACCOUNT:

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PASSWORD:

USERNAME:

PURPOSE OF THIS ACCOUNT:

## PLEASE CHECK THE CALL SCRIPT OPTIONS YOU WOULD LIKE FOR US TO USE BELOW

OUR CALL SCRIPT **(Example)**:

THANK YOU FOR CALLING (THERAPIST/OFFICE NAME), MY NAME IS MAGGIE, HOW CAN I HELP YOU?

CLIENT: DOES (THERAPIST TAKE CIGNA INSURANCE)?

THANKS FOR ASKING ABOUT INSURANCE, I CAN DEFINITELY HELP YOU WITH THAT BUT BEFORE WE DO THAT CAN I GET YOUR PHONE NUMBER IN CASE WE GET DISCONNECTED? IS IT ALRIGHT TO LEAVE A VOICEMAIL? TELL ME A BIT ABOUT WHAT YOU ARE SEEKING HELP FOR, THIS WAY I CAN ASSURE THAT YOU ARE GETTING MATCHED WITH A THERAPIST THAT IS THE BEST FIT FOR YOU PERSONALLY. THANK YOU FOR SHARING, THAT GIVES US A BETTER IDEA OF HOW WE MAY HELP (THERAPIST NAME) SPECIALIZES IN **\_\_\_\_**\_\_ AND WOULD BE AN EXCELLENT FIT FOR YOUR NEEDS AND HERE IS WHY..................... I AM HAPPY TO SCHEDULE A FREE PHONE CONSULTATION WITH THE PROVIDER IF YOU WOULD LIKE TO GET TO KNOW EACH OTHER A BIT BETTER.  EARLIER YOU ASKED ABOUT INSURANCE, (THERAPIST NAME) DOES NOT ACCEPT YOUR INSURANCE BUT THIS MAY ACTUALLY WORK OUT TO YOUR BENEFIT. Most clients prefer to privately pay for session as insurance companies request client records including session notes often for review and require therapist to provide a mental health diagnosis that goes into your permanent medical record. A mental health diagnosis is required or the insurance company will not cover the cost of therapy services. It is common that mental health benefit plans dictate the amount of sessions you are able to receive. Meaning, you may be required to end therapy abruptly due to the terms of your insurance plan which can interfere with your progress. WE ARE HAPPY TO SUBMIT OUT-OF-NETWORK BILLS FOR YOU ON YOUR BEHALF. WHAT THIS MEANS IS THAT YOU MAY GET REIMBURSED FOR A PORTION OF THE PROVIDER’S FEE BY YOUR INSURANCE COMPANY. WE ARE HAPPY TO CONTACT YOUR INSURANCE COMPANY FOR YOU TO CHECK ON OUT-OF-NETWORK COVERAGE AMOUNTS FOR YOU IF YOU WOULD LIKE. I HAVE AN APPOINTMENT OPEN AT THIS DATE AND THIS TIME, WOULD THAT WORK FOR YOU? THE THERAPIST’S FEE PER SESSION IS..........THE THERAPIST CANCELLATION POLICY IS............. WE REQUIRE A CREDIT CARD TO BE STORED ON FILE FOR YOU TO HOLD YOUR FIRST SESSION AND YOUR CREDIT Card WILL BE CHARGED IF YOU MISS AN APPOINTMENT. AND NOW I NEED AN EMAIL ADDRESS FOR YOU SO I CAN SEND OVER OUR FORMS FOR YOU TO COMPLETE BEFORE YOUR FIRST SESSION. IS IT ALRIGHT IF WE SEND EMAIL/AND OR TEXT APPOINTMENT REMINDERS? LASTLY, HOW DID YOU HEAR ABOUT (THERAPIST NAME)? GREAT! YOU ARE CONFIRMED FOR YOUR APPOINTMENT WITH (THERAPIST) AT (THIS TIME ON THIS DATE). YOU WILL RECEIVE AN EMAIL SHORTLY AND A LINK TO FILL OUT OUR FORMS. THANK YOU FOR REACHING OUT TO US TODAY. IT IS A POSITIVE DECISION TO START COUNSELING AND WE ARE GLAD TO HELP. LET ME KNOW IF THERE IS ANYTHING ELSE I CAN HELP YOU WITH IN THE MEANTIME.

* USE YOUR PERSONAL CALL SCRIPT (**Please Attach A Copy of Your Preferred Call Script With This Document**)
* USE THE REVITALIZED THERAPIST’S CALL SCRIPT ABOVE

## PLEASE CHOOSE HOW YOU WANT REFERRALS TO BE PROVIDED

* HAVE US MATCH YOUR CALLER WITH A PROVIDER
* USE YOUR PREFERRED REFERRALS LIST (**Please Attach A Copy of Your Preferred Referral List Spreadsheet Using the Following Categories):** PROVIDER NAME, AGES OF CLIENTS, TYPE OF THERAPY, PHONE NUMBER, TYPE OF THERAPY AND WEBSITE

**ENTER/ATTACH ANY OTHER IMPORTANT INFORMATION YOU THINK WE WILL NEED TO SERVE YOU BETTER (e.g. spread sheets, policies, any systems used for tracking and compiling data):**

## Information Needed to Work with Your Insurance Companies

* LIST **CAQH PROVIEW** PASSWORD AND LOGIN:
* LIST **CAQH ENROLLMENT HUB** PASSWORD AND LOGIN:
* WHAT CLAIMS DO YOU BILL UNDER YOUR **GROUP NPI**?:
* LIST PTAN NUMBER(S) **IF YOU HAVE THEM**:

**PTAN 1:**

LIST INSURANCE COMPANY PAYER/BRANCH OF MEDICARE/JURISDICTION (e.g., MUTUAL OF OMAHA, MEDICARE A/B MAC Jurisdiction 5):

**PTAN 2:**

WHAT INSURANCE COMPANY/BRANCH OF MEDICARE/JURISDICTION)

* PLEASE ATTACH A COPY OF YOUR W9

HAVING A COPY OF YOUR W9 WILL ALLOW US TO USE ACCURATE PRACTICE INFORMATION WHEN THERE IS A NEED TO COMPLETE ANY APPLICATION ON YOUR BEHALF. FOR EXAMPLE, YOUR W9 WILL BE USED IF WE NEED TO CHANGE OR UPDATE INFORMATION FOR INSURANCE PURPOSES, ENROLL YOU IN ELECTRONIC EOBS, EFT, OR TRANSITION YOUR PRACTICE INTO ANOTHER EHR.

* LIST THE INSURANCE COMPANIES YOU WORK WITH

|  |  |  |  |  |  |
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|  | A | B | C | D | E |
| 1 | INSURANCE COMPANY |  |  |  |  |
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**INSURANCE COMPANY PORTAL WEBSITE(S):**

            WEBSITE:

            INSURANCE COMPANY

            LOGIN:

            PASSWORD:

**INSURANCE COMPANY PORTAL WEBSITE(S):**

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            INSURANCE COMPANY

            LOGIN:

            PASSWORD:

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           PASSWORD:

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