**Instructions for Sample Intake Form**

This intake form is designed to be tailored to your clinic’s needs for collecting client information for the purpose of billing. You may delete or insert questions, or change questions and response options as needed. Both English and Spanish examples are provided at the end of the document.

There are several places in the document that you may want to review to ensure that it meets your needs**:**

1. In the sample form, there are only two options for sex: Female or Male, with a space for comments to accommodate trans clients. Most insurance companies require that sex be defined as Male or Female. Depending on the use of the form and your population, you may want to include additional options for clinical reasons.
2. **Contact options** include both voice and text. You can delete the text fields if this is not a function you use. If you are not texting your clients you can also delete the cell phone carrier field.

However, it is especially efficient for appointment reminders or to contact a patient to please return for test results. **Never put personal information such as a reason for visit or actual test results in a text.** To send a text message you only need to use an email address (listed below by carrier) and send a short message. Just substitute the 10-digit cell number for ‘number’ for each carrier below as the “To” address:

|  |  |
| --- | --- |
| * + **AT&T**: number@txt.att.net   + **T-Mobile**: number@tmomail.net   + **Verizon**: number@vtext.com   + **Sprint**: number@messaging.sprintpcs.com or number@pm.sprint.com   + **Virgin Mobile**: number@vmobl.com   + **Tracfone**: number@mmst5.tracfone.com   + **Metro PCS**: number@mymetropcs.com | * + **Boost Mobile**: number@myboostmobile.com   + **Cricket**: number@sms.mycricket.com   + **Nextel**: number@messaging.nextel.com   + **Alltel**: number@message.alltel.com   + **Ptel**: number@ptel.com   + **Suncom**: number@tms.suncom.com   + **Qwest**: number@qwestmp.com   + **U.S. Cellular**: number@email.uscc.net |

1. **For Section 2:** If a patient answers that they have insurance but they not giving permission to bill that insurance, they will need to have it explained to them that they will be billed according to your clinic policies, which should be clearly communicated at this time (e.g. by sliding scale). [Please see: [Sample Communication with Patients about Fees](http://stdtac.org/wp-content/uploads/2016/05/Comm-Materials_STDTAC.doc)].

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **Age:**

**Sex:** Male Female

Please provide information where we **can** contact you below:

**Address:**  **City:**  **State:** **Zip:**

* Home
* Work
* Cell
* Home
* Work
* Cell

**Phone 1: Phone 2:**

**Cell Phone Carrier (if applicable):** (e.g. Verizon/AT&T/Sprint)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may contact me via text messaging:Yes No

**Email Address:**

### **1.****What kind of health insurance do you have?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None

### ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group:

### Name of Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

### Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Are we billing your visit to your insurance today? Yes No

If fees for services are a financial hardship to you, we will be happy to discuss payment arrangements, at your request.

**2a.** I understand that if my insurance is billed that the primary person with the insurance (e.g. yourself, parents or spouse) may become aware of this visit. **Based on the potential loss of confidentiality to the holder of your insurance policy, do you give permission to bill your insurance?** Yes No

I authorize the release of any medical or other information necessary to process this insurance claim. I also request payment of government benefits either to myself or to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Hispanic/Latino Ethnicity (check one):**

* Yes
* No
* Unknown/Not Reported

**3a. Race (check all that apply):**

* White
* Black / African-American
* American Indian */* Alaskan Native
* Native Hawaiian or Pacific Islander
* Asian
* Unknown / Not Reported

1. **Are you able to understand your visit today in English?** Yes No
2. **Have you been to this clinic before?**  Yes No
3. **Emergency Contact:** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **Age:**

**Sex:** Male Female

**Section 1: Are there any changes to your contact information since you were last here? If not, skip this section.**

Please provide information where we **can** contact you below:

**Address:**  **City:**  **State:** **Zip:**

* Home
* Work
* Cell
* Home
* Work
* Cell

**Phone 1: Phone 2:**

**Cell Phone Carrier (if applicable):** (e.g. Verizon/AT&T/Sprint)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may contact me via text messaging:Yes No

**Email Address:**

**Section 2: Are there any changes to your insurance information since you were last here? If not, skip this section.**

If fees for services are a financial hardship to you, we will be happy to discuss payment arrangements, at your request.

### **What kind of health insurance do you have?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None

### ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group:

### Name of Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

### Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Are we billing your visit to your insurance today? Yes No

# I understand that if my insurance is billed that the primary person with the insurance (e.g. yourself, parents or spouse) may become aware of this visit.

# Based on the potential loss of confidentiality to the holder of your insurance policy, do you give permission to bill your insurance? Yes No

I authorize the release of any medical or other information necessary to process this insurance claim. I also request payment of government benefits either to myself or to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nombre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha de nacimiento:** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **Edad:**

**Sexo:** Masculino Femenino

Por favor proporcione información para que podamos comunicarnos con usted:

**Dirección:**  **Ciudad:**  **Estado:** **C.P.:**

* Hogar
* Trabajo
* Celular
* Hogar
* Trabajo
* Celular

**Teléfono 1: Teléfono 2:**

**Compañía teléfonica (si es aplicable):** (por ejemplo, Verizon/AT&T/Sprint)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ puede contactarme a través de mensajes de texto:Sí No

**Correo electrónico:**

**1.** *¿***Qué tipo de seguro médico tiene?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ninguno

Número de identificación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grupo:

Nombre del asegurado principal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha de nacimiento: \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Relación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **¿Quiere que mandemos la factura de su visita de hoy al seguro médico?** Sí No

Si los costos de los servicios son una dificultad financiera para usted, estamos disponibles para discutir diferentes acuerdos de pagos.

**2a.** Tengo entendido que si se manda la factura al seguro médico, la persona principal asegurada (por ejemplo, usted, sus padres, o esposo/a) podrían llegar a enterarse de esta visita. **En base a la posible pérdida de confidencialidad al titular de la póliza de seguro, ¿da permiso de mandarle la factura a su seguro médico?** Sí No

Autorizo la divulgación de cualquier información médica u otra información necesaria para procesar esta reclamación al seguro. También solicito el pago de beneficios de gobierno, ya sea para mí o para la Clínica \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Firma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **¿Es usted hispano o latino? (marque una):**

* Sí
* No
* Desconocido / No reportado

**3a. Raza (marque todas las que apliquen):**

* Blanco
* Negro o afroamericano
* Amerindio o nativo de Alaska
* Hawaiano o Isleño del Pacífico
* Asiático
* Desconocido / No Reportado

1. **¿Es capaz de comprender su visita de hoy en inglés?** Sí No
2. **¿Ha estado en esta clínica antes?**  Sí No
3. **Contacto de Emergencia:** Nombre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relación:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teléfono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dirección: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nombre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha de nacimiento:** \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_ **Edad:**

**Sexo:** Masculino Femenino

**Sección 1: ¿Hay algún cambio en su información de contacto desde su última visita a la clínica? Si no hay, salte esta sección.**

Por favor proporcione información para que podamos comunicarnos con usted:

**Dirección:**  **Ciudad:**  **Estado:** **C.P.:**

* Hogar
* Trabajo
* Celular
* Hogar
* Trabajo
* Celular

**Teléfono 1: Teléfono 2:**

**Compañía teléfonica (si es aplicable):** (por ejemplo, Verizon/AT&T/Sprint)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ puede contactarme a través de mensajes de texto:Sí No

**Correo electrónico** **:**

**Sección 2: ¿Hay algún cambio en su información de seguro médico desde su última visita a la clínica? Si no hay, salte esta sección.**

Si los costos de los servicios son una dificultad financiera para usted, estamos disponibles para discutir diferentes acuerdos de pagos.

*¿***Qué tipo de seguro médico tiene?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ninguno

Número de identificación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grupo:

Nombre del asegurado principal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha de nacimiento: \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_

Relación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**¿Quiere que mandemos la factura de su visita de hoy al seguro médico?** Sí No

Tengo entendido que si se manda la factura al seguro médico, la persona principal asegurada (por ejemplo, usted, sus padres, o esposo/a) podrían llegar a enterarse de esta visita.

**En base a la posible pérdida de confidencialidad al titular de la póliza de seguro, ¿da permiso de mandarle la factura a su seguro médico?** Sí No

Autorizo la divulgación de cualquier información médica u otra información necesaria para procesar esta reclamación al seguro. También solicito el pago de beneficios de gobierno, ya sea para mí o para la Clínica \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Firma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_