Client Intake Form – Insurance/Self-Pay

Date: ___________________________

Client Name: ____ DOB: ________________________________

Address: ____

Phone #: ____ Email: ________________________________

Diagnosis: ____

PCP Name: ____

PCP Phone #: ____ PCP Fax #: ____________________________

PCP Address: ____

Services Requested: ____

Availability: ____ Are you interested in telehealth? Y N

How did you hear about BBTC? ____

Insurance Carrier: ____

Name of Insured:____ DOB:_________________________________

Insured's Employer: ______________________________________ Phone #: ______________________________

Employer Address: ____

Group #: _____________________________________Policy #: ____

Member ID #: ________________________________ SS#: ____

Guardian Name: ____

Guardian Phone#: ____________________________ Guardian Email:__ _________________________________

Emergency Contact: ___________________________ Emergency Contact Phone #: ________________________

Case Manager: ______________________________ Case Manager Phone #: _____________________________

Case Manager Fax#:__________________________ Case Manager Email: _______________________________

Additional Comments: ____

Please send the completed form along with a copy of your insurance card (front & back) to
admin@buildingbridgestherapy.org or via fax to 214-975-1012.