Thank you for contacting Creekside. We need some information so that we can assist you in getting the care that you need. This information will help us decide where to begin the evaluation process. Please complete this two page form and return it by mail: **Appointment Desk, Creekside Psychiatric Center, 5190 Bayou Blvd, #6, Pensacola, FL 32503** or by FAX to **(850) 476-2558**.

You should also download our release of information form to help you begin to gather information about any previous treatment. And we can use this form to help coordinate care with your primary physician.

We will respond to your request for help but our review of this information does not establish a treatment relationship with any provider at Creekside. It is possible that your problems would be better addressed in a different setting.

YOUR NAME	RELATIONSHIP	BEST DAYTIME CONTACT PHONE

HOW WERE YOU REFERRED TO CREEKSIDE?	REFERRED TO A SPECIFIC PROFESSIONAL

CHILD'S NAME	DATE OF BIRTH	AGE	GENDER M F	SOCIAL SECURITY NO.

MAILING ADDRESS	CITY STATE ZIP	HOME PHONE

SCHOOL AND GRADE	TEACHER / GUIDANCE COUNSELOR

FATHER	AGE	OCCUPATION	WILL BE INVOLVED IN CHILD'S TREATMENT ☐

MOTHER	AGE	OCCUPATION	WILL BE INVOLVED IN CHILD'S TREATMENT ☐

OTHERS IN HOME

DESCRIBE THE PROBLEMS THAT YOUR CHILD IS HAVING NOW

TELL US ABOUT ANY PREVIOUS MENTAL HEALTH TREATMENT
CURRENT TREATMENT PREVIOUS THERAPY MEDICATIONS HOSPITALIZATIONS

HOW CAN WE CONTACT YOU TO SET AND CONFIRM APPOINTMENTS?	MAY WE LEAVE A MESSAGE ON A RECORDER? YES NO

WHO IS YOUR PRIMARY CARE PHYSICIAN	
CURRENT MEDICATION	PRESCRIBED BY:

BILLING AND INSURANCE INFORMATION

Patients are responsible for the cost of professional services provided at Creekside Psychiatric Center. To help you fulfill this obligation, we will clarify payment arrangements prior to starting treatment. We will make an effort to determine the amount of your personal financial responsibility.

Your health insurance may provide benefits for treatment. The staff at Creekside will work with you to determine available benefits. We are not responsible for the accuracy of information provided by your insurance company. The benefits may be controlled by a managed care company. There may be limits on frequency of visits, total number of visits, and amount of insurance payment per visit.

At your request, we will file insurance claims and submit bills to third parties. We have contracts with some insurance carriers and will accept assignment. You would be responsible for your deductible and co-payment according to your contract and payment is expected at the time of service. If you expect payment from other parties we will require full payment from you and assist you in getting reimbursed by the other party.

If your insurance company requires preauthorization for treatment, we will help you with this process. Usually, treatment is authorized for a limited number of visits. Managed care companies often require periodic review before authorizing continued treatment. You should monitor the number of authorized visits and any time limits. You are liable for the cost of unauthorized treatment unless prohibited by our contract with your insurance carrier.

A managed care company may require reports of your treatment and, in rare cases, may request a review of your entire record. We are sensitive to your expectation that your treatment will be conducted with confidentiality. However, we cannot assure that confidentiality will be maintained when reports or records are submitted to managed care organizations. You are encouraged to review reports prepared for your insurance company.

> PRIMARY INSURANCE	CUSTOMER SERVICE PHONE		MENTAL HEALTH PRE-CERT PHONE	
POLICY /SUBSCRIBER/ MEMBER NO.	GROUP NO.		EMPLOYER	
POLICYHOLDER NAME	SOCIAL SECURITY NO	DATE OF BIRTH		RELATIONSHIP TO PATIENT
> SECONDARY INSURANCE	CUSTOMER SERVICE PHONE		MENTAL HEALTH PRE-CERT PHONE	
POLICY /SUBSCRIBER/ MEMBER NO.	GROUP NO.		EMPLOYER	
POLICYHOLDER NAME	SOCIAL SECURITY NO	DATE OF BIRTH		RELATIONSHIP TO PATIENT
> TERTIARY INSURANCE	CUSTOMER SERVICE PHONE		MENTAL HEALTH PRE-CERT PHONE	
POLICY /SUBSCRIBER/ MEMBER NO.	GROUP NO.		EMPLOYER	
POLICYHOLDER NAME	SOCIAL SECURITY NO	DATE OF BIRTH		RELATIONSHIP TO PATIENT