SantagatiTherapy.com
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NEW PATIENT INFORMATION

Name (First, Last):____DOB:____/____/____
(name as written on insurance card)

Current Home/Living Address:____

Town:________________________________State:_____________Zipcode:__________________

Email:____ o.k. to leave email? _________

Cell Phone:____o.k. to leave message? _______

*Primary Address Listed with Insurance Co (if different):___________________________________

Emergency Contact:___________________________Relation:_________Phone #:_________________

*Initial; I agree to contact this person in emergency and/or as clinically indicated:___________________

Insurance Information: Client is responsible for checking out of network benefits.

PRIMARY Health Insurance Company:____

Policy Member ID Number:______________________________________

GroupNumber:_________________________________

Insurance Co. Claims Address :____
(behavioral/mental health paper claims for MA, as seen on card)

Insurance Co. Claims PAYER ID:____
(behavior/mental health electronic claims for MA; call them if not visible on your card.)

Insurance Co. Provider Phone Number:____
(number for behavioral/mental health providers as listed on card)

***If applicable; client are responsible for submitting secondary claims to Secondary Insurance Co.

Payment Information on File

Credit/Debit Card Number:___________________________Exp:___/___/___Code: _____Zip:_________

*Signature; I agree to charge this card for past due invoices: _____________________________________