BRAIN AND BODY INTEGRATION, PC

1115 ELKTON DR, STE 300, COLORADO SPRINGS; 6000 EAST EVANS AVE, BLDG 2, STE 200, DENVER 80222;719-357-6471

*Required

*Date Received:

*SCHEDULE IN (Colorado Springs or Denver):

*Client name:

*Gender:

Language Client speaks:

*Do you or your client experience any of the following:

☐Legal Blindness

☐Limited Mobility

☐Nonverbal or ☐ Limited Verbal Skills (can't speak in 3-4 word phrases)

☐Not fluent in the English language

*Guardian name (if applicable):

*Client's DOB:

*Grade (if 18 yrs or under):

*Home Address:

*Phone number:

*Email:

*Primary Insurance:

*Policy Holder (only for non-Medicaid/Medicare referrals):

*Policy Holder DOB & Social (only for non-Medicaid/Medicare referrals):

*Group # (if applicable-only for some 3rd party payers):

*Insurance/Policy #(s)/Tricare SS:

*Tricare beneficiary # for client (DOD – on back of military ID):

*Is Tricare policy holder active duty:

***Any other Insurances (if yes, please list):**

***Referring Provider (or who referred you)**:

***Referring Provider Contact Info:**

***Type of assessment (ie psych, neuro psych (includes all but autism), adaptive/IQ, learning disorder or autism)**:

***Relevant Info**: (or see below) –

***Please answer the following 2 questions**:

"Please provide me with a brief summary of the emotional and behavioral symptoms that are causing you concern?":

Also, note if they are currently involved in mental health treatment (note what type and for how long):