**Neuropsychology Service, P.A.**
**277 State Street Suite 2A, Bangor, ME 04401**
**Phone: 207-990-2580 Fax: 207-990-1930**

**INTAKE INFORMATION – CHILD** Provider: MM RGG LB

Date of intake _____ Taken by _____ □ Full □ Half **Appt. date** _____ Time _____

**PATIENT NAME** _____ DOB _____ Age _____ □ M □ F
Address _____
Phone (h) _____ Phone (M / F's work) _____ Phone (M / F's cell) _____

Names of biological parent(s) _____
If parents divorced, other parent's name and contact info _____
_____
Custody □ Sole ⇒ *Parent must document custodial rights*
□ Joint ⇒ *Both parents must be notified of, and consent to, the eval*
Guardian name (if not a biological/adoptive parent) _____
⇒ *We must obtain consent of guardian for eval*

Current or most recent school _____ _____ Current grade_____
Name of teacher who knows pt best _____
Other pertinent pt info _____

**REFERRAL INFORMATION**
Referring person _____ of _____
Address _____
Phone _____ Fax _____

Referral question _____
_____

Pertinent diagnoses / hx / complaints _____
_____
_____
_____
_____
Any factors that might limit the child's ability to participate in the evaluation? □ No □ Yes _____
_____

Any prior evaluations? □ No □ Yes _____
Any litigation issues? □ No □ Not yet, but possible based on circumstances
□ Yes Specifics_____
⇒ *Contact atty for referral and payment arrangements?* □ Yes □ No (eval will be clinical only)

**INSURANCE INFORMATION**
Insurance Co _____ Phone _____
Name of insured _____ Insured's SSN _____ Rel'p to insured _____
Insured's ID # _____ Certificate/Group # _____
Insured's place of employment _____
Permission to contact insurance co. to verify coverage / eligibility for this eval? □ Yes
□ No Treat as self-pay ⇒ $1500 down-payment due by first appt date, remainder due at FB

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PCP _____of _____
PCP address _____
PCP phone _____ PCP fax_____ NPI _____

**OTHER PAYORS**
Agency / Individual responsible for payment _____
Address _____
Phone _____ Fax _____
Specific rate / hours authorized _____
Authorized by _____on (date) _____

**OTHER PROVIDERS / INVOLVED PARTIES**
Guardian ☐ No ☐ Yes _____ Rel'p to pt _____
Address / Phone_____

Neurologist ☐ No ☐ Yes _____
Address / Phone_____

Psychiatrist ☐ No ☐ Yes _____
Address / Phone_____

Psychologist ☐ No ☐ Yes _____
Address / Phone_____

Social Worker ☐ No ☐ Yes _____
Address / Phone_____

Agencies ☐ No ☐ Yes _____
Address / Phone_____
Address / Phone_____

Attorney ☐ No ☐ Yes _____
Address / Phone_____

Hospitals treated at: _____
_____
_____

**OTHER INFO OR COMMENTS**
_____
_____
_____
_____
_____
_____
_____
_____