Intake Form

Patient Name:
Date of Birth:
Address:
Phone Number:

Point of Contact *(if not the patient):*

Preferred Method of Contact: *(check all that apply)*
☐Phone: ☐Email ☐Text:

Payment Method: ☐Private Pay
☐Insurance *(if yes, please fill out the health insurance verification form)*

Physician Name: **Contact:**
Speech Therapist Name:
Location of Services:
Contact:
Permission to contact for collaboration and medical records?: ☐ yes ☐no

Cognitive Communication Deficits Secondary to: *(check all that apply)*

☐ Traumatic Brain Injury
☐ Stroke
☐ Tumor
☐ Infection
☐ Concussion
☐ Developmental Delay
☐ Autism
☐ Other

Seeking Defy Therapy Services for: *(check all that apply)*

☐ Consultation
☐ Cognitive Communication Evaluation
☐ Cognitive communication treatment
☐ Feeding Evaluation
☐ Feeding Therapy

Availability to Schedule Services: *(check all that apply)*

Day: ☐ Monday ☐ Tuesday ☐ Wednesday ☐Thursday ☐ Friday

Time: ☐ Mornings ☐ Afternoon ☐ Evenings

Location of Services to be provided: *(check all that apply)*
☐In Person ☐Virtual ☐Both

If In Person, specify the location & address where services would be provided:

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Please include and additional information that you would like us to know or is important for your treatment. If applicable, please provide any scripts for any services.

Patient Name_____

Signature_____

Printed Name _____ Date

Relationship to the Patient (if applicable)_____

Health Insurance Verification Form

Patient Name: Date of Birth:
Primary Insurance: Phone Number:

☐ In Network ☐ Out of Network
Member Name: Employer: Group
Member ID #: Number#
Effective Date: / /
Is pre-authorization required? ☐Yes ☐ No
Co-Pay Amount: $
Deductible: Individual: $ Family: $ Out of Pocket Max: $
Progress Towards Deductible to Date:$
Number of visits allowed:
Coverage for therapy services:

Additional details / documents needed:

Secondary Insurance (if applicable): Phone Number:

☐ In Network ☐ Out of Network
Member Name: Employer: Group
Member ID #: Number#
Effective Date: / /
Is pre-authorization required? ☐Yes ☐ No
Co-Pay Amount: $
Deductible: Individual: $ Family: $ Out of Pocket Max: $
Progress Towards Deductible to Date:$
Number of visits allowed:
Coverage for therapy services:

Additional details / documents needed:

Insurance Company Spoken With: ☐Primary Insurance ☐Secondary Insurance

Authorization Number:

Call Reference Number:
Date and Time of Call:

Person Spoke With: