BLUE SKY RANCH
HORSES • HOPE • HEALING

PATIENT INTAKE FORM

PATIENT INFORMATION

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Mailing Address:		Apt #
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact for Appointment Reminder Calls or other Electronically Generated Messages:

(Please select only one option): VOICE ○ TEXT ○	Please select preferred number: Home ○ CELL ○ WORK ○	
Family Physician or Pediatrician:	Date of Birth:	Sex: Male ○ Female ○
Marital Status:	Social Security Number:	
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone #:	Relationship to patient:	

Additional Information and Responsible Party

Responsible Party - if the patient is a minor (under the age of 18), the parent of guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security Number:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient

Additional Information **(Please fill out ALL sections below)**:

Email Address:	Can we leave a message with you regarding your medical care? YES ○ NO ○

Insurance Information	PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
	Insurance Company Name:	Insurance Company Name:
	Policy Holder Name:	Policy Holder Name:
	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
	Policy Holder's Social Security Number:	Policy Holder's Social Security Number:
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Blue Sky Ranch (BSR) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to BSR all money to which I am entitled for medical expenses related to the services performed from time to time by BSR, not to exceed my indebtedness to BSR. I authorize BSR to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from BSR by text or email at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such emails or texts may not be secure and there is a very slight risk that they may be read by a third party.

Medical Beneficiaries: I request that payment of authorized Medicare benefits be made to BSR. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Blue Sky Ranch's Privacy Notice. ☐ (Initials)

Signature of Responsible Party:

X Date:

Printed Name of Responsible Party:

X Date:

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IMMEDIATE FAMILY MEMBERS	RELATIONSHIP TO PATIENT	AGE	GRADE IN SCHOOL	LIVE AT HOME Y/N

How did you hear about Blue Sky Ranch Therapy Services?

If you were referred to us, who were you referred by?

Are you involved with other agencies (Probation, DCF, Employer, etc.?)

State, in your own words why you are requesting help:

On a scale of 0 - 10, how motivated are you to make the changes needed to be successful in therapy?

0	1	2	3	4	5	6	7	8	9	10
No motivation		Interested, but not real into it			Will try, but will need encouragement			Self-driven - will work hard		

Current Medications:

Signature of Responsible Party:

X Date:

Printed Name of Responsible Party:

X Date: