Sweetser Affiliate Network
Client Demographic - Digital Signature

Client Name: (First Name, MI, Last Name)

DOB: (MM/ DD / YYYY) **Client ID:** **Date of Service:** (MM/ DD / YYYY)

– – – –

Affiliate: (First Name, Last Name) **Affiliate Number:**

Date of Referral (SA Only):		New Case ☐	Case Reopening ☐	Date of last discharge:	

If case reopening, date of most recent assessment/annual: _____

(Document can be relied upon and does <u>not</u> have to be resubmitted if it is less than 1 year old.)

Check all that apply for services you are providing:

☐Psychotherapy (individual) ☐Co-Occurring therapy (individual) ☐Medication Management
☐Group psychotherapy ☐Co-Occurring group therapy ☐Med Mgmt with psychotherapy
☐Substance Abuse ☐Psychological testing

Client Information

SS#	Gender: ☐F ☐M (Must match gender on file with insurance company.)	Primary Language: ☐English☐ French ☐Spanish ☐ASL ☐Other
Marital Status: ☐Married ☐Partnered ☐Widowed ☐Separated ☐Single ☐Divorced		
Address:		City:
State:	ZIP:	County:
Home Phone: Okay to Leave message ☐Y ☐N	Work Phone: Okay to Leave message ☐Y ☐N	Cell/Other Phone: Okay to Leave message ☐Y ☐N
Number in Household (supported by annual household income):		Annual Household Income: $
Student Status: ☐None ☐Full Time ☐Part Time		
Education: Highest grade completed:_____	☐GED ☐Post HS Technical ☐Some College ☐Associate's ☐Bachelor's ☐Some Graduate degree ☐Master's ☐Doctoral ☐Declined to answer	
Employer Name:		
Occupational Status :	☐Not Employed – Looking for Work ☐Not Employed – Not Looking for Work ☐Self-Employed ☐Competitively Employed Full Time ☐Working with Supports Full Time ☐Working with Supports Part Time ☐Volunteer ☐Retired ☐Student ☐Information Not Available	
Ethnicity: ☐ _____ ☐ Unknown ☐ Declined to answer	Race: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaska Native ☐Other	
Religion: ☐ _____ ☐Declined ☐Unknown		

Relations and Emergency Contacts **Legal guardian info required if applicable**

Relation to client:	First and Last Name:

☐Financially Responsible ☐Legal Guardian ☐Emergency Contact

Client Name: (First Name, MI, Last Name)

DOB: (MM/ DD / YYYY) – – **Client ID:** **Date of Service:** (MM/ DD / YYYY) – –

Relations and Emergency Contacts continued

Address:		City:
State:	ZIP:	County:
Home Phone:	Work Phone:	Cell/Other Phone:

If relation is Subscriber of Insurance or Financially Responsible for the client, please complete below subscriber information:

SS#	Date of Birth:	Gender: ☐F ☐M
Employer:		
Relation to client:	First and Last Name:	

☐Financially Responsible ☐Legal Guardian ☐Emergency Contact

Address:		City:
State:	ZIP:	County:
Home Phone:	Work Phone:	Cell/Other Phone:

If relation is Subscriber of Insurance or Financially Responsible for the client, please complete below subscriber information:

SS#	Date of Birth:	Gender: ☐F ☐M
Employer:		

Insurance Information

Primary Insurance:	Primary Insurance Phone Number:	
Claims address:		
Policy Holder Name:	(must complete relationship section for the subscriber if other than self)	
Primary Policy No.:	Primary Policy Group No.:	
Effective date of coverage:	Deductible amount:	Deductible met:
Co-Pay amount:	Co-Insurance amount:	Annual limit:
Managed Care Name:	Managed Care Phone No.:	
Authorization required: ☐Yes☐ No	Authorization No:	
Total sessions authorized:	Authorization start date:	expiration date:

Are you doing your own commercial insurance billing? ☐Yes ☐No

Sweetser Affiliate Network
Client Demographic - Digital Signature

Client Name: (First Name, MI, Last Name)

DOB: (MM/ DD / YYYY) – –

Client ID:

Date of Service: (MM/ DD / YYYY) – –

Secondary Insurance:	Secondary Insurance Phone Number:	
Claims address:		
Policy Holder Name:	(must complete relationship section for the subscriber if other than self)	
Secondary Policy No.:	Secondary Policy Group No.:	
Effective date of coverage:	Deductible amount:	Deductible met:
Co-Pay amount:	Co-Insurance amount:	Annual limit:
Managed Care Name:	Managed Care Phone No.:	
Authorization required: ☐Yes☐ No	Authorization No:	
Total sessions authorized:	Authorization start date:	expiration date:

Referral Source:

☐ Affiliate website ☐ Client self-referral
☐ Sweetser Promise Line ☐ External provider*

*If referred by external provider, were supporting documents requested from referrer? ☐ Yes ☐ No

Authorizations to Release Confidential Information were signed by the client for (check all that apply):

☐ Referral source ☐ Other: _____
☐ Collateral provider(s) ☐ None signed at intake.
☐ Family members ☐ Client declined to sign authorizations for (list all that apply):

_____

Behavioral Health:

DSM-5 Code	DSM-5 Description	Specifier(s) – as appropriate

Medical Conditions – Complete as needed:

Note: Always include all relevant information about medical conditions in the **narrative** portion of assessments and annuals. **Please complete this section of the diagnostic document only if you include both the diagnostic code and description as confirmed by a medical provider.**

Diagnostic Code	Description of Medical Condition Matching the Diagnostic Code

Signature date below indicates first date of service and effective date of diagnosis:
Affiliate Signature:_____ Credentials: _____ Date: _____
(By signing, I acknowledge that the services provided and hereby referenced are in compliance with all applicable regulations and laws.)