Saratoga Center For Social Therapy

Initial Contact Form

Today's Date…	

I would like help with…	

Identified Client	

Client DOB		Client Age		Is therapy LEGALLY mandated?	

Referral Source		Who is responsible for bills?	

Client Street Address	

City		State		Zip Code	

Client Phone#'s:	Home#		Cell#		Work#	

Client Email Address	

Check any that apply…

It is OK to send me postal mail	
It is OK to leave me phone voicemail messages	
It is OK to send me email	

Emergency Contact Name		Relationship to Client		Emergency Contact Phone#	

Billing Contact Name		Relationship to Client		Billing Contact Phone#	

Primary Insurance Company		Employer/Source of Insurance	

Mental Health Phone#		Provider's Phone#		Customer Service Phone#	

Subscriber/Contract Holder Name		Subscriber/Contract Holder DOB	

Member ID#		Group#	

Client's Relationship To Subscriber		Co-Pay Amt		Deductible? Y/N	

Subscriber Street Address	

City		State		Zip Code	