

SPECIAL MUSIC, INC.
Neurologic Music Therapy Services

INTAKE FORM

(Please Print)

Today's Date:			Primary Care Physician (PCP):		
CLIENT INFORMATION					
Client's last name:		First:	Middle:	Preferred therapy days/times:	
Previous MT or NMT? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred to NMT by:	Reason for referral:		Birth date:	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Cell phone #: ()	Home phone #: ()	
P.O. box:	City:	State:		ZIP Code:	
Primary Diagnosis:	Primary Care Clinic (PCC):			PCC phone #: ()	
Referred to SM by (Please check one box): <input type="checkbox"/> School <input type="checkbox"/> Physician <input type="checkbox"/> Speech Therapy clinic <input type="checkbox"/> OT Clinic <input type="checkbox"/> Hospital					
Heard about SM by: <input type="checkbox"/> Friend <input type="checkbox"/> Web site <input type="checkbox"/> Brochure <input type="checkbox"/> Other					
Chose SM because:					

INSURANCE INFORMATION (IF APPLICABLE)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone #: ()	
Is this person a client here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Employer:	Employer address:			Employer phone #: ()	
Is MT or NMT covered by your primary insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> Health Partners <input type="checkbox"/> BCBS of MN <input type="checkbox"/> Preferred One <input type="checkbox"/> U Care <input type="checkbox"/> Medicare					
<input type="checkbox"/> Medicaid <input type="checkbox"/> Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group #:	Policy #:	Co-payment: \$
Client's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Do you have a Consumer Support Grant (CSG)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Fiscal Intermediary (FI):		<input type="checkbox"/> Lifeworks		<input type="checkbox"/> MRCI <input type="checkbox"/> Orion <input type="checkbox"/> Other	
FI address:	FI Case Manager (CM):	CM phone #:	CM email:		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to client:	Home phone #: ()	Work phone #: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Special Music, Inc. or insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	