Appointment Date & Time: \_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_ Fiscal: Y or N

Client ID: Insurance Type: Date Verified:

Co-Pay: Amount: $ Deductible: \_\_\_\_\_\_\_\_\_\_ Amount $ \_\_\_\_\_\_\_\_\_\_ Initials:



20231 Paint Boulevard 850 Leonard Street

Shippenville, PA 16254 Clearfield, PA 16830

(814) 226-1159 (814) 205-4004

Fax (814) 227-2876 Fax (814) 205-4013

**FAMILY INTERVENTION THERAPY**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Referral:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If juvenile, list parent/caregiver’s names and addresses:

**F.I.T. Evaluation (choose appropriate plan below)**

\_\_\_\_\_\_ For non-offending spouses, family members, parents of juvenile offenders, and other significant people in the sex offender’s life.

\_\_\_\_\_\_ Domestic Violence, family members related to a Domestic Violence Offender (Includes ADS Testing)

\_\_\_\_\_\_ Anger Management, non-offending family members impacted by the anger (Includes ADS Testing)

**Frequency as indicated by therapist:** Individual session $120.00

**Summary of Agency Concerns:**

Referral Source Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is responsible for the payment of services (client, agency, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Insurance Information:

Agency will be paying for this appointment, if client has no insurance: \_\_\_\_ Yes \_\_\_\_ No

Agency will be paying for this appointment, even though client may have insurance coverage due to extenuating circumstances: Yes No

**\*\*\*\*PLEASE INCLUDE CASE HISTORY AND ANY OTHER IMPORTANT INFORMATION REGARDING THE CASE THAT WILL ASSIST IN TREATMENT\*\*\*\***