

Focused Solutions, LLC

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Work # \_\_\_\_\_

Employer: \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Email Address: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Complete if patient is a child:

School: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work # \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work # \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Patient's EAP. Co. \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's Authorization #: \_\_\_\_\_ Case #: \_\_\_\_\_

Are you the Employee?: \_\_\_\_\_ If No, Your Relationship to the Employee: \_\_\_\_\_

Patient's Primary Ins. Co. \_\_\_\_\_

Phone # \_\_\_\_\_

Membership # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Address: \_\_\_\_\_

Policy Holder Information:

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Authorization # \_\_\_\_\_

If we are unable to contact you, please list the closest relative or friend:

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

Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim, payment of medical benefits to the physician or supplier of services and the release of medical information to my primary care physician.

**Signed** \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ Referred by \_\_\_\_\_