ANXIETY & AGORAPHOBIA TREATMENT CENTER
112 Bala Avenue, Bala Cynwyd, PA 19004
610.667.6490; Fax 610.667.1744
www.aatcphila.com

Name_____ Date_____

Address _____ Age_____ Date of Birth_____

_____Zip _____

Phone (_____)_____home ok to leave message? Y N

(_____)_____ office ok to leave message? Y N

(_____)_____ cell ok to leave message? Y N

Email Address: _____ ok to use this? Y N

Occupation _____Education _____

Marital Status _____ Spouse's Name _____ Spouse's Occupation _____

Children_____ At Home _____

Emergency Contact_____ Phone (_____) _____

Referral Source _____

Previous Therapy _____

Medications _____

I accept responsibility for payment in full for all services rendered at the Anxiety and Agoraphobia Treatment Center.

_____Signature _____Date

Insurance: Do you have insurance to cover services here? _____We can submit your visits directly to your insurance company if we have the necessary mailing information and a copy of your card on file. Would you like us to do this?_____
I authorize the release of any medical or other information necessary to process insurance claims.

_____Signature _____Date
We will assist you as much as possible with insurance reimbursement. However, please understand that your insurance company makes all final decisions regarding eligibility at the time they process your claim. If you have any concerns about coverage, you should contact them directly. We cannot be held responsible for decisions insurance companies make regarding coverage.

For Office Use: Initial Intake completed by _____

Therapist_____Availability_____

Diagnosis:I_____II_____

III_____ IV_____V GAP Current: _____ Past Year:_____