WC PSYCHNET | TELEVATECOMP CARE

PATIENT INTAKE FORM

Patient Name:	Patient DOB: Gender:
Address:	Phone:
Claim#:	Date of Injury:
Email:	

WORKERS COMPENSATION INFO

Carrier: Jurisdiction:	Billing Address: Phone:
Adjuster:	NCM:
Phone:	Phone:
Fax:	Fax:
Email:	Email:
Alt Contact for Authorization or Billing Inquires: Name: Email:	
Employer:	

ATTORNEY INFORMATION

Plaintiff Attorney:	Defense Attorney:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

TRANSFER OF CARE ASSESSMENT

Previous Psychiatric Care Provided? ☐ Yes ☐ No	Psychiatric Medications Previously Prescribed? ☐ Yes ☐ No

APPOINTMENT REQUESTED

☐ Eval Only ☐ Eval and Treat ☐ IME ☐ 2nd Opinion ☐ SCS Clearance

MEDICAL RECORDS AND BILLING

Do you agree to the electronic delivery of medical records and invoices?

☐ Yes VIA ☐ RESPONSIBLE PARTY EMAIL ☐ RESPONSIBLE PARTY FAX ☐ BOTH

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EMAIL:
REFERRALS@WCPSYCH.COM

SUBMIT