Centering Elements

Outpatient Initial Screening

Part I: Client Information

Client Information

Name:		**Client ID#:**	**Date of Initial Contact:**
Date of Birth:	**Age:**	**Gender:** ◯ Male ◯ Female	**Marital Status:** ◯ Single ◯ Married ◯ Divorced
Address:		**City:**	**State:** Virginia / **Zip:**
Home Telephone:	**Cell Phone:**	**Email:**	

Guardian / Authorized

Guardian/Authorized Name:		**Relationship:**	
Address:		**City:**	**State:** Virginia / **Zip:**
Home Telephone:	**Cell Phone:**	**Email:**	

Emergency Contact

Emergency Contact:		**Relationship:**	
Address:		**City:**	**State:** Virginia / **Zip:**
Home Telephone:	**Cell Phone:**	**Email:**	

Part II: Screen Information

Screening Date:	**Name of screening employee:**
Presenting needs or situation:	
Client's treatment preferences:	
Screening recommendation:	

Part III: Referral Information

Agency:			
Referral Name:		**Email:**	
Address:		**City:**	**State:** / **Zip:**
Telephone:	**Cell Phone:**	**Fax:**	

Part IV: Insurance Verification

Insurance Company:	**Phone #:**	**Fax #:**	
Insurance Rep:	**Policy #:**	**Authorization Required: Yes ☐ No ☐** **Authorization #:**	
Claims Mailing Address::	**City:**	**State:** Virginia	**Zip:**
Group Name/#:	**Effective Date:**		
Subscriber:	**Relationship to client:**	**Social Security #:**	**Subscriber DOB:**
In Network: Yes ◯ No ◯	**Co-Pay:**	**Covers:**	
Service: OP Mental Health	**Deductible:**	**Amount Met:**	
OOP:	**Amount Met:**	**Then Covers:**	
Visitation Limits:			
Address:	**City:**	**State:** Virginia	**Zip:**
Telephone:	**Fax:**	**Email:**	