# Screening / Eligibility / Scheduled Assessment

Name: _____

Appointment Time: _____

Appointment Date: _____

Contact Info (if not self)

Name: _____ Phone Number: _____

Date: _____ Time: _____ Relationship: _____

Client Info

Name: _____ DOB: _____

SS#_____

Address, City, State, Zip: _____

Phone: _____

Emergency Contact: Name: _____ Phone: _____

Employer: _____

Funding Source:

_____Insurance Company: _____

_____Private Pay Who: _____

_____County Which: _____

Complete all pages of form and send to us. Email: info@pathwaystoabetterlife.com or Fax: 920-894-1373

Name of county funding Agent (Request authorization be sent) _____

Contact Phone # for Provider: _____

Policy #/Member #: _____

Group #/Subscriber#: _____

Group Name: _____

Coverage Start Date: _____

Outside of Network/Residential Treatment

Coverage amount: _____

_____% Covered, remaining _____% of expenses is considered co-insurance.

Deductible is _____/individual and _____/family

Co-Pay is_____ Authorization Required: Y / N

Phone number to call for Authorization: _____

Demographic and History of Client: _____

_____

_____

_____

_____

History of Abuse: _____

_____

_____

Drug of Choice: _____

_____

Date and amount of last use: _____

_____

Prior Treatment: _____

_____

Current Medications: (all medications must be accompanied by a doctor's order) _____

_____

_____

_____

Health Issues: _____

_____

_____

History of seizures: _____

Legal Issues: _____

_____

Probation Agent/County: _____

Medical Clearance Form (TB, Hep C, STDs) needs to be completed before admittance.

If detox is needed, order needs to be faxed to Pathways prior to treatment, and referral sent to Pathways Detox.

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