

CURE COUNSELING & ASSESSMENT TRAINING CENTRE

2594 Highway 34 East #B
Newnan, GA 30265
(770) 252-3760 office@curecounseling.com

Children's Intake & Bio-Pyschosocial Assessment

Child's Name: _____ Date: _____

Child's age: _____ Date of Birth: ____ / ____ / ____ Sex (circle one): Male Female

Address: _____

Street

City

State

Zip

Parents / Stepparents

Mother's name: _____ Age: _____ Education: _____ Occupation: _____

Father's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Marital status of parents: _____ If parents are separated/divorced, how old was child at time of separation? _____

With whom does the child live? _____

Custody: ☐ Lives in one home with both legal parents. ☐ Mother has physical custody.

☐ Father has physical custody.

☐ Physical custody is shared.

☐ Other: _____

List all people living in household:

Name

Age

Relationship to child

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |

If any brothers or sisters are living outside the home, list their names and ages:

If any brothers / sisters are deceased, please give name and year: _____

FAMILY INFORMATION:

Place of birth: _____

Child's Race: ☐African-American ☐Caucasian ☐Native American ☐Hispanic ☐Asian ☐Latino ☐Other
(specify) _____

Was the child adopted? ☐Yes ☐No If yes, at what age? _____ From where? _____

Has the child ever been placed outside of the home? ☐Yes ☐No If yes, where? _____

In how many residences has the child lived since birth? _____

Has the child been physically or sexually abused, assaulted or molested? ☐Yes ☐No ☐Don't know

If yes, specify by whom and when: _____

Have the child's parents or any other family members had any mental health or emotional problems?

☐Yes ☐No If yes, describe: _____

PRESENTING PROBLEM:

Briefly describe your child's current difficulties: _____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Has the child received evaluation or treatment for the current problem or similar problems? Yes ____ No ____

If yes, when and with whom? _____

Is the child on any medication at this time? Yes ____ No ____

If yes, please note kind of medication: _____

How do you want your child's situation to be different after coming here? _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

- | | |
|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Has difficulty with speech | <input type="checkbox"/> Has frequent tantrums |
| <input type="checkbox"/> Has difficulty with hearing | <input type="checkbox"/> Has frequent nightmares |
| <input type="checkbox"/> Has difficulty with language | <input type="checkbox"/> Has trouble sleeping (describe) _____ |
| <input type="checkbox"/> Has difficulty with vision | <input type="checkbox"/> Has blank staring spells |
| <input type="checkbox"/> Has difficulty with coordination | <input type="checkbox"/> Rocks back and forth |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Bangs head |
| <input type="checkbox"/> Does not get along well with other children | <input type="checkbox"/> Holds breath |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Eats poorly |
| <input type="checkbox"/> Is shy or timid | <input type="checkbox"/> Is stubborn |
| <input type="checkbox"/> Has poor bowel control (soils self) | <input type="checkbox"/> Is much too active |
| <input type="checkbox"/> Is more interested in things (objects) than in people | |
| <input type="checkbox"/> Engages in behavior that could be dangerous to self (describe) _____ | |

Describe child's relationship with his / her:

Father _____

Mother _____

Sibling(s) _____

Step parent(s) _____

OTHER INTERPERSONAL RELATIONSHIPS:

How do you describe the child's friendships:

☐ No Friends ☐ Only Acquaintances ☐ Both acquaintances and close friends

How many close friends? _____

Place a check next to any behavior or problem that your child currently exhibits.

Check

_____ Has special fears, habits, or mannerisms
(describe) _____
_____ Show daredevil behavior
_____ Gives up easily
_____ Wets bed

Check

_____ Is impulsive
_____ Sucks thumb
_____ Is slow to learn
_____ Other (describe): _____

EDUCATIONAL HISTORY

School: _____ Grade: _____

Place a check next to any educational problem that your child currently exhibits:

Check

_____ Has difficulty with reading
_____ Has difficulty with arithmetic
_____ Has difficulty with spelling
_____ Has difficulty with writing

Check

_____ Has difficulty with other subjects (please
list) _____

_____ Does not like school

Is your child in a special education class? Yes _____ No _____

If yes, what type of class? _____

Has your child been held back in a grade? Yes _____ No _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____

If yes, please describe: _____

Has your child ever been suspended or expelled? Yes _____ No _____

If yes, please describe: _____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes _____ No _____ If yes, what kind? _____

During pregnancy, did mother smoke? Yes _____ No _____ If yes, how many cigarettes each day? _____

During pregnancy, did mother drink alcoholic beverages? Yes _____ No _____ If yes, what did she drink?

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? Yes _____ No _____ If yes, what kind? _____

Were forceps used during delivery? Yes _____ No _____

Was a Cesarean section performed? Yes ____ No ____ If yes, for what reason? _____

Was the child premature? Yes ____ No ____ If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes ____ No ____ If yes, please describe: _____

Were there any feeding problems? Yes ____ No ____ If yes, please describe: _____

Were there any sleeping problems? Yes ____ No ____ If yes, please describe: _____

As an infant, was the child quiet? Yes ____ No ____

As an infant, did the child like to be held? Yes ____ No ____

Were there any special problems in the growth and development of the child during the first few years?
Yes ____ No ____ If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

| Behavior | Age | Behavior | Age |
|---------------------------|-------|----------------------------|-------|
| Showed response to parent | _____ | Put several words together | _____ |
| Rolled over | _____ | Dressed self | _____ |
| Sat alone | _____ | Became toilet trained | _____ |
| Crawled | _____ | Stayed dry at night | _____ |
| Walked alone | _____ | Fed self | _____ |
| Babbled | _____ | Rode tricycle | _____ |
| Spoke first word | _____ | | |

CURRENT HEALTH INFORMATION:

Describe child's health generally: ☐Good ☐Fair ☐Poor Is the child sexually active? ☐No ☐Yes

List any health problems the child has had: _____

Does the child have:

Current immunizations ☐No ☐Yes Which are needed? _____

Any allergies ☐No ☐Yes Specify _____

Nutritional problems ☐No ☐Yes Specify _____

Appetite problems ☐No ☐Yes Specify _____

Sleep problems ☐No ☐Yes Specify _____

A disability or handicap ☐No ☐Yes Specify _____

Contagious or other diseases ☐No ☐Yes Specify _____

Any accidents / injuries ☐No ☐Yes Specify _____

Dental, vision or hearing problems ☐No ☐Yes Specify _____

Any hospitalizations ☐No ☐Yes Specify _____

Physician: _____

Name

City

Date of last contact: ____ / ____ / ____ Reason for last contact: _____

SUBSTANCE USE / ABUSE:

Please complete the chart below

| Category of Drug | Has child ever used? | Currently using? | Age at first use | How often does child use? | How taken? | How much? | Use last 48 hours? | Withdrawal symptoms |
|------------------|----------------------------------------------------------|----------------------------------------------------------|------------------|---------------------------|------------|-----------|--------------------|---------------------|
| Alcohol | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Stimulant | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Cocaine | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Tranquilizer | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Barbituate | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Marijuana | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Opiod | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Hallucinogen | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Prescribed | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Nictine | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Caffeine | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Other | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |

FAMILY MEDICAL HISTORY:

Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

| Check | Condition | Relationship to child |
|-------|------------------|-----------------------|
| _____ | Alcoholism | _____ |
| _____ | Cancer | _____ |
| _____ | Diabetes | _____ |
| _____ | Heart trouble | _____ |
| _____ | Bipolar Disorder | _____ |
| _____ | Anxiety Disorder | _____ |

| Check | Condition | Relationship to child |
|-------|---------------------|-----------------------|
| _____ | Depression | _____ |
| _____ | Learning disability | _____ |
| _____ | ADHD | _____ |
| _____ | Mental Retardation | _____ |
| _____ | Other | _____ |

RELIGION / SPIRITUALITY:

Religion: ☐Protestant ☐Catholic ☐Buddhist ☐Hindu ☐Jewish ☐Muslim ☐Atheist ☐Agnostic ☐Other:

LEGAL INFORMATION:

Has the child ever: Had difficulty or contact with police? ☐Yes ☐No
 Appeared in juvenile conference? ☐Yes ☐No
 Been on probation? ☐Yes ☐No

Please explain: _____

OTHER INFORMATION:

What are your child's favorite activities?

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

What activities would your child like to engage in more often than he/she does at present?

1. _____ 2. _____

What activities does your child like least?

1. _____ 2. _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check Disciplinary technique

_____ Ignore problem behavior
_____ Scold child
_____ Spank child
_____ Threaten child
_____ Reason with child
_____ Don't use any technique

Check Disciplinary technique

_____ Tell child to sit on chair
_____ Send child to his or her room
_____ Take away some activity or food
_____ Other technique (describe) _____
_____ Redirect child's interest

Which disciplinary techniques are usually effective? _____

With what type of problem(s)? _____

Which disciplinary techniques are usually ineffective? _____

With what type of problem(s)? _____

What have you found to be the most satisfactory ways of helping your child? _____

What are your child's assets or strengths? _____

PREVIOUS COUNSELING / PSYCHOTHERAPY:

Has your child ever been in counseling / therapy before? ☐ No ☐ Yes

Name of Provider Clinic Year Diagnosis / Problem

Has your child been prescribed psychotropic medication? ☐ No ☐ Yes

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Reason: _____

Other medications currently prescribed:

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Medication: _____ Dosage: _____ Prescribed by: _____

Reason: _____

Check if applicable: ☐ Inpatient ☐ Day Treatment ☐ Substance Abuse Program
☐ Psychological Testing ☐ Partial Hospitalization

Explain any of the above: _____

Has the child ever:

Made a suicide attempt: ☐ No ☐ Yes If yes, when? _____

Expressed homicidal thoughts: ☐ No ☐ Yes Describe _____

Had episodes of explosive anger: ☐ No ☐ Yes Describe _____

Is the child currently expressing homicidal / suicidal feelings? ☐No ☐Yes

* * * * *

Signature of Informant _____ Date _____

Relationship to client _____

CURE COUNSELING & ASSESSMENT TRAINING CENTRE

SNAP ASSESSMENT

CLIENT:

DOB:

DATE:

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><u>STRENGTHS</u></p> <p>What personal qualities do you have which we can build upon in treatment?</p> | <input type="checkbox"/> Open minded <input type="checkbox"/> Friendly <input type="checkbox"/> Creative <input type="checkbox"/> Good Listener <input type="checkbox"/> Quick Learner <input type="checkbox"/> Good Grooming <input type="checkbox"/> Organized | <input type="checkbox"/> Takes personal responsibility <input type="checkbox"/> Strong personal or spiritual values <input type="checkbox"/> Independent <input type="checkbox"/> Assertive <input type="checkbox"/> Hard Worker <input type="checkbox"/> Able to learn from my experiences <input type="checkbox"/> Can collaborate/ work with others | <input type="checkbox"/> Good Problem Solver <input type="checkbox"/> Good Decision Maker <input type="checkbox"/> Dependable <input type="checkbox"/> Motivation <input type="checkbox"/> Good health <input type="checkbox"/> Other (Please List) <hr/> <hr/> <hr/> |
| <p><u>NEEDS</u></p> <p>What would help you achieve your goals? Please, check your most important needs.</p> <p>(Prioritize your top three)</p> | <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> Increase my knowledge of resources that provide me with support <input type="checkbox"/> Referral to resources for job training or education <input type="checkbox"/> Access to medical care for health related concerns <input type="checkbox"/> Staying in a sober environment to help me not use drugs and or alcohol <input type="checkbox"/> Gain more knowledge and understanding about: <div style="margin-left: 20px;"> <input type="checkbox"/> My mental health diagnosis <input type="checkbox"/> My medication(s) <input type="checkbox"/> My symptoms / behaviors related to my mental health diagnosis </div> <input type="checkbox"/> Get help to stop smoking <input type="checkbox"/> Learn how to empower myself to take a more active role in my treatment </div> <div style="width: 48%;"> <input type="checkbox"/> Increasing effective communication skills to improve my relationships with others <input type="checkbox"/> Learn how to talk about my concerns/issues/feelings <input type="checkbox"/> Practice my coping skills in a safe environment <input type="checkbox"/> Learn more about effective coping skills related to: <div style="margin-left: 20px;"> <input type="checkbox"/> Improving my sleep <input type="checkbox"/> Reducing anxiety and using relaxation <input type="checkbox"/> Managing my depression <input type="checkbox"/> Leisure skills <input type="checkbox"/> Organizing daily activities <input type="checkbox"/> Managing anger <input type="checkbox"/> Mood Regulation <input type="checkbox"/> Improving reality-based thinking <input type="checkbox"/> Eating Healthy </div> <input type="checkbox"/> Other (Please List) <hr/><hr/> </div> </div> | | |
| <p><u>Abilities</u></p> <p>What skills do you possess?</p> | <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> Basic ability to read and write <input type="checkbox"/> Computer knowledge and skills <input type="checkbox"/> Ability to work effectively with others <input type="checkbox"/> Knowledge or tools that I use to help me manage my emotions <input type="checkbox"/> Ability to have positive relationships with others </div> <div style="width: 48%;"> <input type="checkbox"/> Ability to make healthy decisions about my life <input type="checkbox"/> Job Skills _____ <input type="checkbox"/> Education / Training _____ <input type="checkbox"/> Leisure Skills _____ <input type="checkbox"/> Ability to manage my time and structure my daily activities <input type="checkbox"/> Other (Please List) </div> </div> | | |
| <p><u>Preferences</u></p> <p>How do you want your treatment?</p> | <input type="checkbox"/> I prefer my family or friends to be involved in my treatment <input type="checkbox"/> I would like to have a family meeting I learn new information better: <div style="margin-left: 20px;"> <input type="checkbox"/> Face to face <input type="checkbox"/> Hands on instruction and practice <input type="checkbox"/> Reading written material <div style="margin-left: 20px;"> <input type="checkbox"/> Alone <input type="checkbox"/> In discussion with others </div> <input type="checkbox"/> Sharing information in a group of my peers </div> | <input type="checkbox"/> I would like to live: <div style="margin-left: 20px;"> <input type="checkbox"/> Independently, on my own <input type="checkbox"/> Independently, with community support <input type="checkbox"/> With others <input type="checkbox"/> Other ideas I have about my living situation (Please List) <hr/><hr/><hr/> </div> | <input type="checkbox"/> I am interested in learning more about <div style="margin-left: 20px;"> <input type="checkbox"/> Outpatient programming <input type="checkbox"/> Community resources <input type="checkbox"/> Other areas of interest (Please List) <hr/><hr/><hr/> </div> |



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> <input type="checkbox"/> PICA | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | |
| <input type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No., Street) | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| CITY STATE | | 7. INSURED'S ADDRESS (No., Street) | |
| ZIP CODE TELEPHONE (Include Area Code) () | | CITY STATE | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 8. RESERVED FOR NUCC USE | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| b. RESERVED FOR NUCC USE | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| c. RESERVED FOR NUCC USE | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | b. OTHER CLAIM ID (Designated by NUCC) | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| X SIGNED DATE /2023 | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d. | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| 15. OTHER DATE MM DD YY QUAL. | | X SIGNED | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| A. B. C. D. E. F. G. H. I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER | | 23. PRIOR AUTHORIZATION NUMBER | |
| F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. # | | | |
| 1 | | NPI | |
| 2 | | NPI | |
| 3 | | NPI | |
| 4 | | NPI | |
| 5 | | NPI | |
| 6 | | NPI | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> | | 26. PATIENT'S ACCOUNT NO. | |
| 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28. TOTAL CHARGE \$ | |
| 29. AMOUNT PAID \$ | | 30. Rsvd for NUCC Use | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | 32. SERVICE FACILITY LOCATION INFORMATION | |
| SIGNED DATE | | a. NPI b. | |
| 33. BILLING PROVIDER INFO & PH # () | | a. NPI b. | |

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.