Path to Awareness, PC

dba Rogue Valley TMS in Medford and dba Badlands TMS in Bend
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Circle One:
Location: RV BL
Provider: CB JA BH LB
TMS? : Yes No

Insurance Intake

This form is required for all clients who are covered by insurance / EAP/ managed care.

1. Client Name: _____ DOB: _____
   Sex Assigned at Birth: □ Female □ Male
   Gender Identity: _____ • Preferred Pronouns _____

   Address_____

   Phone:_____ Alternate Contact: _____
   Is it alright to leave confidential messages? □ Yes □ No

Email: _____
Email may not be a confidential form of communication. Your email will not be shared or solicited. Listing your email here constitutes permission to send protected health information via email.

2. Name of Primary Insured: _____ DOB: _____

   Relationship to insured: _____ Employer: _____

3. Insurance Company: _____ Phone: _____
   This policy is: □ Primary □ Secondary // Do you have another insurance? □ Yes □No
   Are you covered by the Oregon Health Plan/Medicaid? □ Yes □ No Medicare? □ Yes □ No

   ID#: _____ Group # _____
   Check one: □ Health Insurance □ EAP □ Worker's Comp □ Auto Insurance □ Medicare □ Medicaid

****** PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD**

I hereby authorize Path to Awareness, PC and appointed billing agent(s) to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) _____ for the purpose of claims payment. I understand that failing to include information about all insurance and other plans that cover me may result in a larger than expected out of pocket expense for me.

(Optional) I would like to authorize _____ to receive billing/financial information on my account. (Please attach a release of information form to indicate specific preferences).

I further authorize payment of medical & mental health benefits to Path to Awareness, PC for services provided.

Signed: _____ Date: _____
Relationship to Client: □ Self □ Other: _____
The billing office will reach out to you by email with an estimate of out-of-pocket expense within 2 business days of receiving your insurance information. Please contact the billing office at billing@professional-practice.org or Phone (541)234-4781 if you have not received an estimate within 5 days of submitting this form.

For Office Use Only: INN / OON
Ph _____ Dt ____/_____/_____ Rep _____ Eff ____/____/____
Ded _____ _____ □ Cal □ Plan: _____ Pd@ _____ Co _____ Net _____
V Limit _____/_____ MN □ Auth □ PEC Wait □Exempt _____
OOP _____ Other: _____
Eml ____/____/____ Cl pt ___/____/____ @ ____:_____ □LM □Ph □ Eml □Mail