

NEW CLIENT REFERRAL FORM

Today's Date:

Client Name: _____ DOB (mm/dd/yyyy): _____

Legal Name (If Different): _____ Gender Identity: _____ Pronouns: _____

Sex Assigned at Birth (Required for Insurance Purposes Only): _____

Mailing Address: _____

Phone: _____ Is it okay to leave you voicemails? _____ Email: _____

Relational Status: _____ Are you a Student? _____ School/Grade: _____

Do you have a partner, friend, or family member who is working with an Art of Awareness Provider?

If so, please provide the name of the therapist & partner/friend/family member:

Are you employed? _____ Where do you work? _____

Emergency Contact Name, Relation, and PH#: _____

Do you have any allergies? _____ If yes, please list: _____

Do you have a PCP? _____ PCP Name & Practice: _____

Are you currently working with any other healthcare providers (e.g. nutritionist, psychiatrist, medical specialists)?

Please list their Name & Profession: _____

How did you find out about Art of Awareness? _____

Are you currently seeing a therapist? _____ Current Therapist's Name: _____

If Yes, are you looking to switch individual therapists? _____

Have you sought therapy in the past? _____ Past Therapist's Name: _____

Are you open to Telehealth Therapy Yes No No Preference/First Available

Are you open to Biweekly appointments? Yes No No Preference

Topics to be addressed in therapy (REQUIRED):

Therapist Preference: Male Female No Preference/First

What type(s) of therapy service(s) are you seeking? Individual Couples Family

Which days and times would work best for you to meet with one of our Clinicians (REQUIRED)?

The following questions may or may not apply to you. We ask each new client these questions. Please answer them to the best of your ability, thank you.

Have you ever been hospitalized for a Mental Health, Substance Use Disorder, or an Eating Disorder related concern?

Y N If Yes, please list when and where:

Are you currently taking medications? Y N If Yes, please list:

Are you currently experiencing any of the following?

Poor Sleep Y N

Change in Appetite Y N

Medical Health Problems Y N If Yes, please list:

Have you experienced any of the following currently or in the past?

(Crisis Line 24/7 PH# 888-568-1112)

Thoughts of Self Harm	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never/Not Applicable
Thoughts of Suicide	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never/Not Applicable
Suicidal Intent or Plan	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never/Not Applicable
Thoughts of physically harming another person	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never/Not Applicable
Homicidal Intent or Plan	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never/Not Applicable

If you answered "yes/current" to the above questions, please reach out to the crisis line (888-568-1112) or go to your nearest emergency room.

Art of Awareness is not a crisis program, we are a by appointment only Therapy Practice and Intensive Outpatient Program. We will get back to you within 72 business hours upon receipt of your New Client Referral. Please reach out to the crisis line if you are in need of immediate support.

How much alcohol do you drink on a weekly basis?

Do you abuse or over-use any drugs? Current Past Never/Not Applicable

Have you experienced any traumatic events? Current Past Never/Not Applicable

Do you have a family history of mental health, substance use disorder, or eating disorders? Y N

Do you have Disordered Eating? Current Past Never/Not Applicable

Overall, on a scale of 1 to 5, to what degree are the symptoms you are experiencing affecting your daily life & functioning?

(1 being not at all, 5 being severely impacting your daily life): 1 2 3 4 5

Resources & Support:

What activities do you enjoy?

Who is in your current support system?

What are your strengths?



Client Insurance and Benefit Form

Please complete the form below to provide Art of Awareness with your insurance coverage details for routine outpatient mental health services. Please note that authorizations and/or estimates for insurance coverage do not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the members contract at the time of service.

If needed, we have included an additional form in this packet called the “Benefit Retrieval Guide for Clients” as a resource to clients to gain their mental health benefit information.

General Insurance Information:

Client Name: _____ Pronouns: _____/_____

Legal Name (If Different): _____ DOB (mm/dd/yyyy): ____/____/____

Email: _____ PH#: _____

For Minors and/or Clients Who Have an Identified Parent/Guardian Point-of-Contact for Billing Related Matters:

Parent/Guardian Name: _____ Relation to Client: _____

Email: _____ PH#: _____

Has an Authorization to Release Information Form Been Signed for Billing Purposes? Y N

If no, and the client would like to identify a Parent/Guardian as a point of contact for billing purposes, the Authorization to Release Information form is included in this packet for the client to complete and submit with this packet.

Insurance Company Name: _____

Subscriber Name: _____ Renewal Date: _____

Member ID#: _____ Group Number: _____

Please Include Alpha Prefix

Insurance Provider Phone Number: 1-(_____) _____ - _____

This phone number can be found on the back of an insurance card, listed as “Provider Phone Number”

****Continued on Next Page***

For Reference:

Art of Awareness Tax ID#: 65-125-4395

Art of Awareness Clinical Director NPI# (Provider: Emily Roberson, LCSW): 1154484236

Client Benefit Information for Routine Outpatient Mental Health (Office and Telehealth):

Copay Per Session: _____

Deductible: Individual: _____ Family: _____

Has the Deductible Been Met? Yes No

Coinsurance %: _____

Max Out-Of-Pocket Amount: Individual: _____ Family: _____

Has the Max Out-Of-Pocket Amount Been Met? Yes No

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Client Signature: _____ Date: ____/____/____

For Clients that are NOT completing this form through the Valant Patient Portal:

Please send your completed packet to billing@artofawareness.org



Benefit Retrieval Guide for Clients

Tips and Language to Support you in Finding out your Coverage for Outpatient Individual, Couples, and Group Mental Health Services (Not applicable for clients pursuing IOP)

Call member services (number on the back of your card) and ask:

1. Do I have a copay or coinsurance for routine mental health services?
2. Do I have a deductible to meet before coinsurance is applied?
 - a. If yes, how much has been met towards my deductible?
3. Is there a session limit?
4. What is the accumulation of my maximum out of pocket expense?
5. Do I need a referral?
6. Are telehealth benefits the same as in office?

If needed, CPT codes are:

90791 for Initial Assessment
90837 for Individual Therapy
90847 for Couples Therapy
90853 for Group Therapy (non IOP)

For HMO Policies - Benefits can be more affordable for clients with a PCP (primary care provider) referral. Consider reaching out to your doctor's office and ask them to provide a referral and have it sent to Art of Awareness at clientservices@artofawareness.org or fax to 207-799-1350. If you may require a referral to access better benefits, best practice would be to request this from your PCP prior to receiving any services.

Other tips to note when making insurance calls:

- AoA's tax ID is 651254395
- The NPI# of Art of Awareness's Clinical Director (Emily Roberson) is: 1154484236
 - Note that this NPI# is only applicable for services received through Art of Awareness, and will not produce accurate benefit information for providers outside of Art of Awareness.
- You can bypass the automated response system by stating "representative" or "agent," or pressing zero "0"
- If you are asked for a diagnosis code, you can say "no diagnosis at this time"

- You will need to provide your legal name associated with your legal sex to receive accurate benefits but can ask to have a preferred name associated with your insurance
 - More movement will be made in the insurance industry with regards to transgender and non-binary gender preferences.
- If your insurance changes (ie change of employment) please inform your therapist and the Billing department at billing@artofawareness.org. This way we can check to make sure your new insurance is in network with your provider.
- *Note that we are not currently in-network with Mainecare*

Once you receive your benefit information:

- Please communicate this to your assigned therapist at Art of Awareness and your therapist will update this information into our Electronic Health Records system, Valant.
- If you find that your benefit information changes, please make sure to update your therapist