aspire health alliance

Child & Family Psychological Services, Inc.
Integrated Behavioral Associates

Call for Intake: (617) 847-1914

Please check desired service

☐ **Outpatient Therapy** ☐ **Outreach Services** (Home/school-based individual therapy)

☐ **IHT Family Therapy** (Intensive family therapy for children with acute concerns)

Client name: _____ Date of Birth: _____

Age: _____ Gender: _____ Race: _____ Ethnicity: _____

Address: _____ City: _____ Zip: _____

Special Needs: (Linguistic/cultural) _____

School: _____ City: _____ Zip: _____

Diagnosis: _____

Parent/Legal Guardian: _____ Phone: _____

Referring Person/Agency: _____ Phone: _____

Reason for Individual Therapy/Justification for IHT: (Why individual therapy alone is insufficient. Explain)

_____

_____

_____

Goals of Treatment: _____

_____

_____

Insurance: ☐ BHS ☐ BMC ☐ MBHP ☐ NetHealth

Insurance ID #: _____

Client's Primary Care Physician:

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

********** ***Office Use Only*** **********

Scan to: **Doreen Draheim**
Divisional Director Outpatient Services
ddraheim@aspirehealthalliance.org

Date Received: _____ **AHA MR#:** _____ **RU#:** _____