Waltham Behavioral Health
Request for Services Form

Please note that you will need your insurance information to complete this form. Please complete all fields so that we may quickly and accurately identify the best clinician to meet your needs. Missing information will delay your request. When completed, please fax it to: **781.915.0755**

Once we have reviewed your information, we will respond with an appointment. You may expect to hear from us within 5 buness days.

First Name: _____
Last Name: _____
Birth date: (for insurance verification) _____
Zip Code: _____
Phone #: _____
May we leave a message at this number? □ yes □ no
May we contact you via email? □ yes □ no
Email address: _____

How did you hear about us or who referred you to us?

□ My Primary Care Doctor
□ Another Mental Health Provider or Physician
□ Friend/Family Member
□ Insurance Company Website / Staff
□ Internet Search
□ My College/University/School
□ Other: _____
Name of institution: _____

I'm interested in: (check all that apply)

□ Individual Counseling
□ Couples Counseling
□ Medication Management
□ Stress Management Training
□ ADD Testing

Note: We typically do not have evening hours available. Saturday appointments are available.
Are you able to attend appointments between 8 am and 5pm □ yes □ no

Insurance / Payment Type:
We accept the following Payment Methods. Please indicate your primary insurance plan below or check the Private Pay box if you do not plan to use your insurance.

□ Private Pay (Check, MasterCard or Visa)
□ Blue Cross Blue Shield of Massachusetts □ HMO □ POS □ PPO
My Policy/Subscriber ID# is (including all letters):_____
□ Blue Cross from another state
State: _____
□ Harvard Pilgrim
□ United Behavioral Health
□ United Healthcare
□ United Healthcare Student Resources
College/University: _____
□ Tufts □ PPO □ POS □ HMO
□ Aetna □ PPO □ POS □ HMO □ Medicare
□ Aetna Student Health Plan □ Other: Please provide name of plan _____

I would like assistance with the following concerns: (check all that apply)

☐ Depression	☐ Anxiety
☐ Stress management	☐ Relationship Issues
☐ Sexuality	☐ Grief or Loss
☐ Adjustment to Illness	☐ Bipolar Disorder
☐ Substance Abuse	☐ Other addictions
☐ ADD/ADHD	☐ Dual Diagnosis

☐ Other/Please Describe: _____

I have the following medical issues: (check all that apply)

☐ Headaches	☐ Back or Neck Pain
☐ Other chronic pain	☐ Gastrointestinal Problems
☐ Reproductive Problems	☐ Diabetes
☐ High Blood Pressure	☐ High Cholesterol
☐ Cardiac Problems	☐ Respiratory Problems
☐ Obesity	☐ Sleep Apnea or other Sleep Problems
☐ Neurological Condition	☐ Concussion/Brain Injury
☐ Endocrine/Thyroid	☐ Menopausal / Other hormonal Problems
☐ Asthma/Respiratory	☐ Allergies

Other: (please describe) _____

Thank you for completing this form. Please fax it to: **781.915.0755** . We will endeavor to contact you within **5** business days to let you know if we will be able to meet your needs.