5675 N Oracle Rd, Suite 3101
Tucson, AZ 85704
Phone: 520.333.3320
www.intuitionwellness.com

Multi-Service Appointment Request

Following is information that may be helpful before completing an appointment request:

- Intuition Wellness Center's providers serve young people, ages birth to 25, and their caregivers.
- Some services may be billable to Blue Cross Blue Shield and Aetna insurances. You may also request a superbill. View Pricing Information.
- Intuition Wellness Center's behavioral health training team provides services at a reduced fee, which are not typically billable to insurance. See benefits to working with our training department.
- Availability is limited. Your flexibility with scheduling will improve the team's ability to serve you. The team responds to all medical service requests on the same day received during business hours. It may take 5-7 business days for the team to formulate a thoughtful response to your request for all other services. Thank you for your patience.

The questionnaire below is required in order to determine Intuition Wellness Center's ability to meet your needs for clinical and/or medical services. This form is not required for classes or events.

Please call 520-333-3320 if you have any questions.

If you are submitting a request for multiple people, please fill out a separate form for each person.

Date: (required)* ______________________________

Your name: (required)* ______________________________

Your email: (required)* ______________________________

Your phone: (required)* ______________________________

Would you like to sign up to receive our emailed parenting tips? (required)* Yes No

Who are you seeking services for? (required)* Self Child Family

If seeking services for someone other than yourself, what is their name? (required)*

____

Sex assigned at birth of prospective client: (required)* Male Female Other

Date of birth of prospective client MM/DD/YYYY: (required)* ______________________________

If prospective client is a child, what school do they attend? ______________________________

School grade: ______________________________

How did you hear about Intuition Wellness Center? (required)* BCBS Aetna Psychology Today Internet (e.g., Google) PCP Other Professional Other

Please expand on who or where: (required)* ____

Do you have a team member preference? (Select ALL that apply; required.)* Team members have limited availability. Flexibility increases the chance of a successful match. [See benefits to working with our training team.]

Counseling-Any Licensed Team Member

Counseling- Supervised Doctoral Student or Clinician Pursuing Higher Licensure

Naturopathic Medical Doctor

Pediatric Occupational Therapist

Psychological Testing-Any Licensed Team Member

Psychological Testing-Supervised Doctoral Student or Clinician Pursuing Higher Licensure

Name of specific team member: ________________________________

What service(s) are you requesting? (Select ALL that apply; required)*

Naturopathic Medicine

Counseling

Play Therapy

Parent Guidance

Psychological Testing

Pediatric Occupational Therapy

Creative Arts Therapy

School Success Consultation

Physical Exam

Sports Physical

Sick Visit

Food Allergies and Intolerances

Nutritional Advice

Vaccination Counseling

Mood and Behavior Issues

Infant and Child Sleep Support

Digestive Concerns

Recurrent Infections

Dermatological Conditions

Handling Puberty Gracefully and Optimally

Parent Education

Please describe your concerns in just a few sentences: (required)*

Is the prospective client seeking treatment for the following? (required)*

Eating Disorder   Addiction   None of these

If so, please provide a little more detail:

Does prospective client have a history of chronic substance abuse? (required)*   Yes   No

If so, please provide a little more detail:

Did prospective client recently attempt suicide? (required)*   Yes   No

If Yes, how recently? ______________________________

Is prospective client currently suicidal? (required)* Yes No

(If so, please call 911 or the crisis line at 866-495-6735 to speak to a crisis counselor.)

Does the prospective client have a history of aggression or violence or are they currently aggressive or violent? (required)* Yes No

If Yes, please provide a little more detail:

Did prospective client recently attempt homicide? (required)* Yes No

If Yes, how recently? ________________________________

Is prospective client currently homicidal? (required)* Yes No

(If so, please call 911 or the crisis line at 866-495-6735 to speak to a crisis counselor.)

Has the prospective client had any past or current legal involvement, including parental divorce proceedings or Department of Child Services (DCS/CPS)? (required)* Yes No

If Yes, please specify:

If requesting services for a child, are both parents available to consent to treatment? (required)*

Yes No N/A, prospective client is an adult

If No, please provide a little more detail:

If requesting services for a child, has either parent's rights been legally terminated? (required)*

Yes No

If Yes, please provide a little more detail:

Who has the power to make medical decisions for the prospective client according to the law? (required)*
Please specify (e.g. Mom, Dad, Stepparent, Grandparent, Guardian, etc)**:**

If applicable, please supply supporting court/legal documents at intake or email PDF documents to contact@intuitionwellness.com prior to your intake appointment. (required)*

Does prospective client have a significant medical complication? (required)* Yes No

If so, please provide a little more detail:

Does prospective client have a previous treatment history? (required)* Medical Behavioral Health

Other None

If so, please provide a little more detail:

If you have previous behavioral health or medical treatment history, please bring a copy of records, e.g., treatment summary, treatment plan, testing reports, etc., to the initial intake appointment. You can also email PDF documents to contact@intuitionwellness.com prior to your intake appointment.

How are you able to pay for services? (Select ALL that apply; required)* See Fee Schedule.

Self Pay (Licensed Team Member) Self Pay (Training Department Reduced Fees)

BCBSAZ Aetna

Insurance ID: ______________________________

Group #: __________________________________

Subscriber name: ______________________________________ **Date of Birth:** __________________

Member Sex Assigned at Birth: (Designated on birth certificate per healthcare insurance) M F

Thank you for your interest in Intuition Wellness Center.

Please email the completed form to contact@intuitionwellness.com.

12-11-23rev