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Chicago, IL 60657
(312) 399-0559

Client Information

Last Name _____ First Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Birthdate of Client _____ Social Security Number _____

Employer and Address _____ Who referred you? _____

Contact Person (in case of emergency only)

Last name _____ First Name _____

Street Address _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Relationship to Client _____

Insurance Provider Information

Insured (guarantor) Full Name _____.

Relationship to Client _____

Social Security Number _____

Insurance Provider _____ Phone No. _____

ID No. _____ Group No. _____

Please provide the therapist with a copy of your insurance identification card.

1. I hereby authorize the therapist whose name appears on my insurance claim form to furnish my insurance company with any requested information concerning my present treatment.
2. I hereby agree to forward to the therapist whose name appears on my insurance claim form any payments sent to me directly from my insurance company for psychological services relative to the services reported on my insurance.

Client Signature

Date

Therapist Signature

Date