Chicago Psychological
WHERE COGNITION MEETS POSITIVE CHANGE

PATIENT INFORMATION

Name: ______________________________ ______________________________ _______ Sex: Male Female
Last First Middle Initial

Address: ____
Street City State Zip Code

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Email: ____

Patient is: Single Married Separated Divorced Other Patient's Social Security #____________________

If Patient is an Adult:

Occupation:__________________Employed by: ____________________________ Business Address: _____________________

If a Minor, Who has Custody or Guardianship: ____

In the event of an Emergency, Who should be notified: ____
Relationship: ____

Phone: ___________________

Referred to Chicago Psychological by whom: ____

ASSIGNMENT AND RELEASE

I certify that I, (or my dependent) have insurance coverage with___________________________________ (insurance company) and assign directly to Chicago Psychological all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize Chicago Psychological to release all information necessary (including diagnoses, mental health records and substance abuse records) to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Person Financially Responsible for Account:_______________________________________(Please Print Name)

Person Financially Responsible for Account:____(Signature)

Relationship to Patient:_____________________ Date Signed: ___________________

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INSURANCE INFORMATION

Patient Name: ____
Name of Patient

Subscriber's Name: ____________________ ____________________ __________
Last First Middle Initial

Relationship to Patient: ________________________ Subscriber's Birthdate: ____________

Subscriber's Social Security #:_____________________

Subscriber's Address: ______________________ ______________ _________ _______
Street City State Zip

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Employer: _______________________________Insurance Company ________ Claims Address ______

Insurance Company Phone: _____________________

Group # :_____________________ Subscriber ID# : _________________

Other Family Members covered under this plan: _______________________________

CoPay Amount (if known): ____________Mental Health Benefits per Year under this plan (if known): ______

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Is there a Secondary Insurance Policy? Yes _________ No ___

If so, please complete the following:

Subscriber's Name: ____________________ ____________________ __________
Last First Middle Initial

Relationship to Patient: ________________________

Subscriber's Birthdate: ____________________ Subscriber's Social Security #:__________________

Subscriber's Address: ______________________ ______________ _________ _______
Street City State Zip

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Employer: __________________________

Insurance Company ____________________________ Claims Address __Insurance Company Phone: ____

Group # :_____________________ Subscriber ID# : _________________

Other Family Members covered under this plan: _ CoPay Amount (if known): ___