Integrative Counseling & Psychological Services, PC

Naperville Location:
616 West 5th Avenue, Suite B • Naperville, IL 60563
630.717.7771 *(office)* • **630.206.2003** *(fax)*

Deerfield Location:
440 Lake Cook Road, Building 1 • Deerfield, IL 60015
847.892.6000 *(office)* • **847.892.6151** *(fax)*

630.418.0280 *(emergency)* • **integrativecps@gmail.com** *(email)*

(please print)

Confidential Client Information

Today's Date: _____ Name of Therapist: _____

Client Information:

PATIENT'S NAME: _____
Last First MI

Soc. Sec. # _____ Driver's License/State I.D. # _____

Address _____ City/State/Zip _____

Home Phone _____ Ok to leave message? Y / N Mobile Phone _____ Ok to leave message? Y / N

Email Address _____ May we contact you at this email*? Y / N

(Note: Confidentiality cannot be guaranteed in cyberspace.)

Sex: M _____ F _____ Age _____ Date of Birth _____ Marital Status _____

Employer/School _____ Work Phone _____ Ok to leave message? Y / N

Emergency Contact _____ Phone _____

Primary Care Physician _____

Address _____ City/State/Zip _____

Referred By _____

Responsible Party Information:

NAME: _____ Relationship to Patient _____
Last First MI

Address *(if different)* _____ City/State/Zip _____

Home Phone _____ Ok to leave message? Y / N Mobile Phone _____ Ok to leave message? Y / N

Email Address _____ May we contact you at this email*? Y / N

(Note: Confidentiality cannot be guaranteed in cyberspace.)

Insured's Employer _____ Work Phone _____ Ok to leave message? Y / N

Primary Insurance _____

Insured's Soc. Sec.# _____ Insured's Driver's License/State I.D. # _____

Insured's Date of Birth _____ ID# _____ Group # _____

Additional Information/Special Instructions/Secondary Insurance: _____

_____

Signed: _____ Date: _____

Notice to Primary Care Physician:

_____Please send my physician a courtesy letter and let him/her know I am seeing you, as well as basic treatment information, (main concern, initial treatment goals). I have the right to inspect information sent and to revoke this permission, if put in writing. Revoking authorization applies to the information not already disclosed. ***(Local HMO patients MUST have information communicated to their PCP.)***

_____Please DO NOT send any information at this time. *(I can give permission later if I wish to do so.)*

Signed: _____ Date: _____

Insurance Reimbursement:

I authorize my clinician to receive payment for services provided. If your coverage requires case management, this authorizes the release of clinical information via telephone, in writing, and by fax, as required by your plan. ***(NHCA Patients: Your signature allows communication of info to your PCP.)***

Signature of Patient: _____ Date: _____

Signature of Insured/Guardian/Responsible Party: _____ Date: _____