CONNECT PSYCHOLOGICAL SERVICES, LLC

1580 South Milwaukee, Ave. Suite 407 Libertyville, Il 60048. 847) 502-5218

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City/State/Zip: _____

Employer/School: _____ Occupation: _____

Email Address: _____ Referred by: _____

Marital Status: Married Partnered Single Widowed Divorced Other

Spouse/Parent Name: _____ Spouse/Parent Phone: _____

Emergency Contact Name and Phone: _____

**Please inform me if you do not want me to leave voice mail messages or send paperwork to your home. Note your preferences or alternate arrangements. _____

INSURANCE INFORMATION

Primary: _____ Secondary: _____

Phone: _____ Type: HMO PPO EPO POS other

Group Name/Number: _____

Policy or ID Number: _____

Responsible Party: _____ Birthdate: _____

Insured Address or Phone if different: _____

I authorize the release of any medical information necessary to process claims for me or my dependents on my behalf, and I authorize payment of benefits to this practice for claims submitted on my behalf.
I understand that I am financially responsible for noncovered benefits and all deductibles not covered by this authorization. I am aware that this provider does not accept Medicare.

I prefer to opt out of using insurance. Initial and Sign OPT OUT form_____

Signature: _____Date: _____