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: _____

Emergency Contact Name: _____Phone: _____
Agreement to contact ER Designated Person: _____
**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. All telehealth clients require a designated ER person or local resource I can contact in an emergency. _____.

INSURANCE INFORMATION (BCBS PPO in network provider)

Primary: _____ Secondary: _____ or [ ] No 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 and/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 and co-payments not covered by this authorization. I understand insurance payment is not guaranteed and some services are not routinely covered. I am aware that this provider is only a BCBS PPO provider, and she does not accept Medicare or Medicaid.

Signature: _____Date: _____

I plan to opt out of using insurance. I understand I am financially responsible for all fees outlined in the service agreement. I understand I will be provided an estimate of my costs called a Good Faith Estimate.

Signature: _____Date: _____