1256 Waterford Drive, Ste 140 Aurora, IL 60504 Phone: 630-898-5322 - Fax: 630-898-5324

NEW CLIENT INFORMATION – ADULT

Patient Name ______________________ Birth Date _____ / _____ / _______

Address ______________________ Patient Gender ☐ Male ☐ Female

Address ______________________

City, State, Zip ______________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouse's Name______________________

CONTACT INFORMATION

Home Phone _____ - ______ - ______ ☐ Okay to Leave Message

Mobile Phone _____ - ______ - ______ ☐ Okay to Leave Message

Office Phone _____ - ______ - ______ Ext __________ ☐ Okay to Leave Message

Email Address ______________________ ☐ Okay to Leave Message

EMPLOYER

Employment Status ☐ Employed ☐ Self Employed ☐ Other ______________________

Employer Name ______________________

PRIMARY INSURANCE INFORMATION

Insurance Carrier ______________________ ID Number ______________

Phone Number ______________________ Group # ______________

Insured's Name ______________________ Insured's DOB ____ /_____ /_____

Insured's Address ______________________ Insured's Phone # ______________

Insured's Employer ______________________

SECONDARY INSURANCE INFORMATION

Insurance Carrier ______________________ ID Number ______________

Phone Number ______________________ Group # ______________

Insured's Name ______________________ Insured's DOB_____/_____/______

Insured's Address ______________________ Insured's phone#______________

Insured's Employer ______________________

For office Use Only

ClientDx____________**InsuranceCoverage**______________**Deductible**___________**Copay**___________**Limits**__________

256 Waterford Drive, Ste 140 - Aurora, IL 60504 **Phone: 630-898-5322 Fax: 630-898-532**

AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 12 months from the date signed.

____

Patient's and/or Guardian's Signature

- ☐ Release any applicable information to my Primary Care Physician
- ☐ Do not release information to my Primary Care Physician
- ☐ Do not currently have a Primary Care Physician

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name ____ Phone _____ - ______ - ______

Address ____

City, State, Zip ____

Credit Card Guaranty of Payment

I understand that Waterford Counseling and Psychological Services will be billing my insurance carrier as a courtesy to me for therapy or psychological services. I further understand that I am responsible for all reasonable and customary fees that my insurance carrier does not cover such as deductibles or copayments. I understand that while Waterford Counseling and Psychological Services provides the courtesy of verifying my benefits, it is my responsibility to know my benefits and to follow up with any and all insurance disputes. If disputed due to the failure of the insurance carrier or me, the payment in full becomes my responsibility.

Because of this, I am giving Waterford Counseling and Psychological Services permission to charge my credit card for any services that have not been paid by me within 90 days of billing. If services have not been paid within 60 days, Waterford Counseling and Psychological services will notify me in writing giving me 30 days in which to resolve the matter with my insurance carrier before payment in full is expected. I understand this form to be valid for three years from the date signed unless I canceled the authorization in writing.

Credit Card Information

____

Patient Name

____

Cardholder Name (if different from patient)

____________________	______________	__________
Billing Address	City	Zip
Credit Card Number	Expiration Date	Security Code (3 digit # on back)
Signature	Date	