WATERFORD
Counseling and Psychological Services

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

NEW CLIENT INFORMATION - CHILD/DEPENDANT

Patient Name _____ Birth Date _____ / _____ / _____

Address _____ Patient Gender ☐ Male ☐ Female

City, State, Zip _____ Phone Number _____

☐ Okay to Leave Message

GUARDIAN CONTACT INFORMATION

Mother's Name _____ Marital Status ☐ Married ☐ Single ☐ Divorced

Address _____

City, State, Zip _____

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

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

Email Address _____ ☐ Okay to Leave Message

Father's Name _____ Marital Status ☐ Married ☐ Single ☐ Divorced

Address _____

City, State, Zip _____

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

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

Email Address _____ ☐ Okay to Leave Message

PRIMARY INSURANCE INFORMATION

Responsible Guardian/Insured _____ Relationship to Child _____

Insurance Carrier _____ ID Number _____

Phone Number _____ Group # _____

Insured's Name _____ Insured's DOB _____ /_____ /_____

SECONDARY INSURANCE INFORMATION

Responsible Guardian/Insured _____ Relationship to Child _____

Insurance Carrier _____ ID Number _____

Phone Number _____ Group # _____

Insured's Name _____ Insured's DOB _____ /_____ /_____

OFFICE USE ONLY

Client Dx _____ Client Fee _____ Deductible _____ Coverage _____ Limits _____

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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