HOME PSYCH SERVICES, P.C.

Quality Behavioral Healthcare
in the Comfort of Your Home™

REGISTRATION FORM

FULL NAME OF CLIENT: _____ TODAY' DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ HOME PHONE: _____ WORK PHONE: _____

CLIENT' BIRTHDATE: _____ AGE: _____ GENDER: _____ MARITAL STATUS: _____

CLIENT' EDUCATION LEVEL: _____ CLIENT'S SSN: _____

CLIENT' OCCUPATION: _____ EMPLOYER: _____

SPOUSE' NAME: _____ AGE: _____ WORK PHONE: _____

Please tell us how you heard about us: _____

If client is a MINOR or DEPENDENT, please complete the following section:

GUARANTOR' NAME: _____ SSN: _____

GUARANTOR'S PLACE OF EMPLOYMENT: _____

WORK ADDRESS: _____

WORK PHONE: _____ If client is a student, what is his/her grade level? _____

What school does client attend? _____

Who is responsible for payment of services? _____

Address, if different from that of client: _____

380 E. Northwest Highway, Suite 340–H • Des Plaines, Illinois 60016
Business Telephone / Pager: (847) 86 PSYCH (7–7924) • **Fax**: (847) 299–4952

INSURANCE AGREEMENT

Most Third-Party payors (insurance companies) require the provider to release information regarding diagnosis, type and place of service rendered, dates of service, and possibly other related confidential information. Other payors may require a treatment plan and/or a periodic review of services. I am unable to control such information after it has been released and the client or responsible parties should realize that there are social and legal risks posed by the release of confidential information to Third-Party payors.

1. Managed Health Care Plans (HMO', PPO', EAP') may reimburse me for professional services. Special arrangements must be made with the Managed Health Care Plan before a third party source will be accepted.
2. If you expect insurance to reimburse you for your payment, please provide the following information so I can assist you by completing the necessary forms.

PRIMARY Insurance Company: _____
Address: _____
Phone Number: _____ Insurance ID Number: _____
Insurance Group Number: _____
Insured' Name: _____ Insured' Employer: _____
Insured' Date of Birth: _____ Insured' SSN: _____

3. The entire insurance deductible must be satisfied before assigning medical benefits.

Deductible $_____ Amt. Paid $_____ Amt. Owed $_____

Thereafter, co-payments are required at the time of service. We accept cash, checks, VISA, or MasterCard.

Co-payment %_____ Est. Amt. $_____

380 E. Northwest Highway, Suite 340-H • Des Plaines, Illinois 60016
Business Telephone / Pager: (847) 86 PSYCH (7-7924) • **Fax**: (847) 299-4952

INSURANCE AGREEMENT (CONT.)

4. If you want this office to complete insurance forms, I need your signature to authorize release of information to the health insurance company and/or its agents.
5. Since health insurance may be used to pay a part of your obligations, this office may accept insurance as a partial reimbursement. You must authorize the insurance company to make such payments directly to HOME PSYCH SERVICES, P.C. However, such an agreement does not release you from the final responsibility for the bill.

I authorize payment of my medical benefits to HOME PSYCH SERVICES, P.C., for partial payment for professional services delivered, and agree to an estimated co-payment of _____ per hourly charge of $160. The insurance policy' annual deductible must be met before assignment of the policy benefits will be accepted. I acknowledge full responsibility for payment of all professional fees. In order to obtain insurance reimbursement, I authorize the release of any information pertinent to my case to any insurance company, managed care agent, adjuster, or attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____ _____

(Signature of Client / Responsible Party) (Today' Date)

_____

(Printed Name)

380 E. Northwest Highway, Suite 340-H • Des Plaines, Illinois 60016
Business Telephone / Pager: (847) 86 PSYCH (7-7924) • **Fax**: (847) 299-4952