Creative Psychology, Ltd.

PATIENT INFORMATION (TO BE FILLED OUT BY PATIENT)

Therapist Initials: ____________

Patient Name: ________________________________ Today's Date: ________________ D.O.B. __________________________

SSN: ________________ Address: _________________________________ City/State: __________________ Zip: _________

Phone (H): ___________________________ Work: _____________________________ Cell: ___________________________

Email: __________________________________Emergency Contact & Phone____

POLICY HOLDER INFORMATION (Must be filled out. If patient is policy holder, please put self)

Policy Holder's Name: _______________________________________D.O.B. ______________ SSN: ______________________

(for insurance purposes)

Address: _______________________________________ City/State: ________________________________ Zip: _________

Phone (H): ____________________________ Work: ____________________________ Cell: ____________________________

Employer: ____

Address: ____

HOW DID YOU HEAR ABOUT US?

- ☐ COURT
- ☐ COUNSELOR/THERAPIST
- ☐ FRIEND
- ☐ SCHOOL
- ☐ YELLOW PAGES
- ☐ FAMILY MEMBER
- ☐ INTERNET/WEBSITE_________________________________
- ☐ INSURANCE
- ☐ OTHER ____

____

PLEASE ATTACH COPIES OF THE FRONT AND BACK OF THE INSURANCE CARD TO THIS SHEET

INSURANCE INFORMATION (TO BE FILLED OUT BY BILLING)

DX: ____ Insurance Phone: _____________________________________

Insurance Company: ____

Policy #: ____ Group #: ____

Name of Insurance Rep: ____________________________ Effective Date: ______________ Date of Initial Call: ______________

Confirmation #:_________________________ Coverage: __________ In Network: __________ Out of Network:______________

Copay: ____________ Deductible: __________________ Out of Pocket: ___________________ Max Benefit: ________________

Visits Per Year: ________ Preauthorization Required: ____ NO ____YES Auth #: __________________Effective To: _________

Treatment Plan Req'd for Reauthorization: ____NO ____YES Mailing Address: ____

Creative Psychology, Ltd.

North Ridge Professional Center, 610 N. Route 31, Suite E, Crystal Lake, Illinois 60012
Phone (815) 444-8469 - Fax (815) 479-1709 – www.creativepsychologyltd.com

Patient Account Ledger

TAX ID#: 80-0059908

Client's Name: ______________________________ DOB: ______________

Address: ______________________________City______________State______Zip__________

Who should we send billing to? (if patient is a minor) Billing Address and Name:______________

____

Phone: Home: ______________ Alt. Number: ______________ Soc. Sec. #: ______________

Diagnosis (ICD/DSM code):

____
(to be filled in by clinician)

Treatment Record:

Date	Service	# of hrs	Charge	Clt.Pd/Ins.Pd	Ins. Disc	Session Bal.	Open Bal.

Insurance:____

Referred by: ____