Ravenswood Counseling Center
5115 N Ravenswood Ave
Chicago, Il 60640

CLIENT INFORMATION

Client Name:_____ Date of Birth:_____

Billing Address:_____ Gender: Male Female _____

_____ Marital Status: S M W D

Email Address:_____OK to Send Correspondence/Statements: Yes No

If Minor (under 18) please write name of legal guardian:_____

Social Security Number:_____

Home Phone:_____ OK to Call?: Yes No

Work /Cell Phone: _____ OK to Call?: Yes No

Employer Name:_____ City:_____

PRIMARY INSURANCE

Insurance Carrier:_____

Phone Number:_____

Identification Number:_____ Group Number:_____

Is Patient Policy Holder?: Yes No Policy Holder Relation to Patient: Self Spouse Child Other

Policy Holder Name:_____Policy Holder Date of Birth:_____

Secondary Insurance Available: Yes No If Yes, Attach Second Demo Sheet

Please read the following carefully and sign below:

I give permission to Ravenswood Counseling Center and the billing staff to send required information to my insurance company(s) or my EAP. I am aware that I am placing my signature of file. I also understand that any unpaid balances such as co-pays, deductibles, and non-covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellations of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed:_____ **Date:**_____

DX:_____**SMI: YES**_____ **NO** _____