

**Lake-Cook Behavioral Health Resources
New Client registration Form**

Client Information:
(Please print clearly)

Date: _____

Client name: _____ Client home phone: _____
Last First Middle initial Area code Number

Client home address: _____ Client work phone: _____

Client date of birth: ____/____/____

Client SS #: ____/____/____

Client gender: male/female *(circle one)* Client marital status: single / married / other *(circle one)*

Client employed: emp. / student *(circle one)* Employer/school: _____

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Billing Information:

Name of parent/guardian responsible for bill: _____
(If client is a minor) *Last First Middle initial*

Address: _____ Home phone: _____

Area code Number
Work phone: _____
Area code Number

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Insurance Information: Bill my insurance? *(circle one)* Yes No

** If more than one insurance company is to be billed, please provide information, note primary carrier and secondary carrier.*

Insurance co. name: _____ Insured's name: _____

Insurance co. address: _____ Insured's SS#: ____/____/____

Insured's Employer: _____

Insured's date of birth: ____/____/____ Group # or name: _____

Insurance phone: _____ Policy #: _____

Authorization #: _____ Client's relationship to insured: self / wife / husband / child / other
(circle one)

Please give your therapist a copy of your insurance card.

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To be filled out by therapist: Self-pay Ins. EAP CAP *(circle one)* Case rate _____

Therapist's name: _____ Program/group name: _____

Diagnosis (DSM IV code): _____ If Medicare/Medicaid ICD9 code: _____

Special notes: _____

Statement sent to home: Yes / No (circle one) Referral source: _____

White copy: chart Yellow copy: office Pink copy: therapist

Account #: _____

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