Psychotherapy Associates of Chicago LLC

Client Registration Information

____ ____________________

Name of Client Date of Birth

____

Address

____

Home Phone Cell Phone Work Phone___

______________________________ _________________________

Email Address SS#

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Parent/Guardian (*if client is under the age of 18*)

Insurance Information (*if applicable*)

____ ____________________

Name of Insured (*if different than above*) Insured's Date of Birth

______________________________ ______________________________

Name of Insurance Plan Name of Employer

______________________________ ______________________________

Identification Number of Insured Group/Policy Number

____________________ ____

Relation to the Insured Insurance Phone Number

Office Use Only

_______________ _______________ _______________ _______________

Deductible Copayment Coinsurance Sessions Allowed

___________________________________ _______________ _______________

Name of Therapist DX C/A Rate