Youth Services
BRINGING KIDS HOPE
McLennan Center for Youth
PotashCorp Campus
3080 West Lake Ave.
Glenview, IL 60026
Office: 847.724.2620
Fax: 847.724.3499
WWW.YSGN.ORG

CLIENT INFORMATION

CLIENT _____ **(DOB)** _____

Phone (H) _____ **Phone (W)** _____

Phone (cell) _____

ADDRESS _____

City _____**Zip**_____

Gender: _____ **Marital Status: Married** ___ **Single** ___ **Other** ____ **Cell phone Carrier:** _____

E-mail _____

If client is a dependent/minor, please give address and phone information of parent/guardian that client lives with

Name/Address _____

Phone (H) _____ **Phone (W)** _____

Phone (cell) _____

How were you referred to Youth Services? _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT _____

Phone (H) _____ **Phone (W)** _____

Phone (Cell) _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____

Date of Birth_____ **EMPLOYER** _____

FAMILY PHYSICIAN _____ **PHYSICIAN'S PHONE** _____

PREVIOUS THERAPY _____

CURRENT MEDICATIONS/ALLERGIES (PLEASE LIST_____

PRESENTING PROBLEM: _____

_____ _____
Signature of client Date

_____
Printed Name

_____ _____
Signature of person acting for client Date

_____
Printed Name

Relationship to client:_____

WILL YOU BE USING YOUR INSURANCE? □YES □NO If no, please sign the following waiver below:

I understand that by initialing this waiver, I agree to pay the full fee at the current rate of $_____ per hour and am financially responsible for payment at time of service.

Signature of Client or person acting for client_____

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INSURANCE CHECKLIST

(Please complete and sign prior to your first visit)

Patient Name: _____Policy Holder: _____

Primary Insurance: _____Effective Date_____

Secondary Insurance: _____Effective Date_____

Prior to your first visit you must call the phone number on the back of your insurance card and ask the following questions:

1. What are my benefits for "out of network" outpatient behavioral health"?

Amount of copay/co-insurance? _____

How many sessions are allowed? _____

Do I have to satisfy a deductible/how much? _____

2. Do I need pre authorization before I can be seen by my therapist?

If yes, what is the authorization # _____

Number of sessions approved _____

Name of rep & date of your phone call _____

3. Is my therapist covered under my benefits package? Yes ___ No ___

If "No", what are my "out of network" benefits? _____

Address where insurance claims should be sent:

_____

_____

****A COPY OF YOUR INSURANCE CARD IS REQUIRED <u>BEFORE ANY CLAIMS CAN BE FILED</u>****
******There is no guarantee of benefits until a claim has been processed and paid*******