Youth Services of Glenview/Northbrook
Client Information + Payment Form

Client + Parent/Guardian Contact Information:

Client Name: _____

Client Date of Birth: _____ Client Age: _____

Client Gender Identity: _____

Client Racial/Ethnic Identity: _____

Client Cell Phone Number: _____

Client E-mail Address: _____

Residence Street Address: _____

Residence City/State/Zip: _____

Residence Phone Number: _____

Parent/Legal Guardian:

- Name / Relationship: _____
- Phone Number Cell: _____
- Phone Number Work: _____
- E-mail: _____

Parent/Legal Guardian:

- Name / Relationship: _____
- Phone Number Cell: _____
- Phone Number Work: _____
- E-mail: _____

Emergency Contact (*other than parents/guardians listed above*):

- Name / Relationship: _____
- Contact Phone Number: _____

Referral Information:

Who told you about and/or referred you to Youth Services?

☐ Insurance Company: _____ ☐ Friend/Acquaintance: _____

☐ Doctor/Provider: _____ ☐ School staff: _____

☐ Online Search ☐ Other: _____

Client Medical Information:

Primary Care Physician/Practice Name: _____

Primary Care Physician Phone Number: _____

Current Medications (Dose, Frequency): _____

Prescribing Physician Name: _____

Prescribing Physician Phone Number: _____

Medical/Dietary Allergies and/or Conditions Limiting Activity: _____

_____

Billing Information:

Who is responsible for payment?

Name(s): _____

Relationship to Client: _____

Date(s) of Birth: _____

Street Address(es) (*if not already listed above*): _____

_____

Phone Number(s) (*if not already listed above*): _____

Payment Information:

Will you be using your insurance?

☐ No.

My agreed-upon private pay fee for intake, sessions, and missed sessions/late cancellations is $_____.

☐ Yes. **Please provide a copy of your insurance card.*

Insurance Provider: _____

Insurance Provider Phone Number: _____

Insurance Group ID: _____

Insurance Member ID: _____

Insurance Plan Effective Date: _____

Name on Insurance ("Insured"): _____

Insured Date of Birth: _____ Insured Sex: _____

Insured Street Address + Phone Number (if not already listed above): _____

_____

Referring Physician (if applicable): _____