

# Counseling Associates of Southern Illinois

## CLIENT INSURANCE INFORMATION

Date\_\_\_\_\_ Client's Social Security #\_\_\_\_\_

Client's First Name\_\_\_\_\_ Last Name\_\_\_\_\_ MI\_\_\_\_\_

Address\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Telephone (Home)\_\_\_\_\_ (Work)\_\_\_\_\_ (Cell)\_\_\_\_\_

Birthdate\_\_\_\_\_ Age\_\_\_\_\_ Gender M F Email\_\_\_\_\_

Name of Spouse/Guardian\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Person Responsible for Payment\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_

Signature of Person Responsible for Payment X\_\_\_\_\_

(Must be signed for services to begin)

### Employment Information (if client is a child, use parent's information)

Client/Guardian: Place\_\_\_\_\_ Phone\_\_\_\_\_

Spouse: Place\_\_\_\_\_ Phone\_\_\_\_\_

### Insurance Information

Primary Insurance\_\_\_\_\_

Secondary Insurance\_\_\_\_\_

Phone\_\_\_\_\_

Phone\_\_\_\_\_

Contract/ID#\_\_\_\_\_

Contract/ID#\_\_\_\_\_

Group/Acct#\_\_\_\_\_

Group/Acct#\_\_\_\_\_

Subscriber\_\_\_\_\_

Subscriber\_\_\_\_\_

Subscriber Date of Birth\_\_\_\_\_

Subscriber Date of Birth\_\_\_\_\_

Subscriber's SS#\_\_\_\_\_

Subscriber's SS#\_\_\_\_\_

Client's relationship to Subscriber  
\_\_Self \_\_Spouse \_\_Child \_\_Other\_\_\_\_\_

Client's relationship to Subscriber  
\_\_Self \_\_Spouse \_\_Child \_\_Other\_\_\_\_\_

### Emergency Information

In case of emergency, contact:

Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name (2) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Allergies \_\_\_\_\_

THE FOLLOWING QUESTIONS ARE FOR INSURANCE PURPOSES ONLY:

Have you had any other mental health appointments this year? If so, how many? \_\_\_\_\_

Have you had any inpatient hospitalizations this year? If so, how many days? \_\_\_\_\_

### Referral Source

How did you hear of our clinic (or from whom)? \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Phone \_\_\_\_\_

May we thank your referral source? YES NO

**Other information**

A courtesy call will be given a day or two in advance to remind you of your upcoming appointment.

\_\_\_\_\_ YES. A courtesy call is okay. Call me at this number \_\_\_\_\_

Can we talk to anyone else at that number? YES NO If yes, who? \_\_\_\_\_

Can we leave a message on an answering machine or voice mail? YES NO

\_\_\_\_\_ NO. Please DON'T CALL OR LEAVE MESSAGES WITH ANYONE ABOUT MY APPOINTMENTS

***If you are unable to keep your scheduled appointment, you must give 24 hours advance notice. If 24 hours notice is not given, or your appointment is missed completely, you will be charged. If 24 hours notice of cancellation is not given, you will be charged \$55.00. The current no show fee is \$75.00. This amount must be paid and is not billable to your insurance company.***

**I understand and 24 hour cancellation/ No Show policy: YES NO**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date