CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

PATIENT INFORMATION FORM

Today's date:	Primary Care Physician:

☐ PATIENT INFORMATION (A)

Client's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms. ❑ Other	Marital status (circle one) Single / Mar / Div / Sep / Wid / Other /

Is this your legal name?		If not, what is your legal name?	Social Security no.:	Birth date:	Gender:		
❑ Yes	❑ No			/ /	❑ M	❑ F	❑ Other

Street address:	Email:	Home Phone:
Line 1:	Preferred Method Of Contact? (Circle)	( )
Line 2:	Home / Cell / Text / Work / Email	Cell Phone:

City:	State:	Zip Code	( )
Employer:			Work Phone:
Employer Address:			( )

Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Website/Internet	❑ Yellow Pages	❑ Other	❑ Self-Pay Client?

☐ INSURANCE INFORMATION (B)

Is this patient covered by insurance? If yes, please complete below and provide a copy of an Insurance ID Card:

Primary Insurance Company:			
Subscriber's Name:	Birth Date:	Policy ID #:	Group #:
	/ /		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Secondary Insurance Company: Applicable? ❑Yes ❑No				
Subscriber's Name:	Birth Date:	Policy ID #:	Group #:	
	/ /			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

☐ PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT(C)

If different than the patient, please complete below:

Responsible Party Name:				Birthdate: / /	Gender:	❑ M	❑ F	❑ Other
Responsible Party's relationship to patient:	❑ Self	❑ Spouse	❑ Child	❑ Other	Social Security #:			

Street address:	Personal E-mail:	Home phone #:
Line 1:		( )
Line 2:		Cell phone #:

City:	State:	Zip Code:	( )
Employer:			Work phone #:
Employer Address:			( )

☐ IN CASE OF AN EMERGENCY CONTACT PERSON: (D)

Name of local friend or relative (not living at same address):	Home phone #:	Cell/Work phone #:
	( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Counseling and Diagnostic Center. I understand that I am financially responsible for any balance not paid by insurance. I also authorize Counseling and Diagnostic Center of Woodfield or insurance company to release any information required to process my claims.

Parent / Guardian Signature:	Date: / /

FINANCIAL TERMS OF TREATMENT

1. 48 hour notice of cancellation is required. If cancellation is made after this time you will be charged a cancellation fee in the amount of $75.00. In case of an emergency, death in the family, hospitalization, illness, etc., please speak with your therapist regarding this fee.
2. The undersigned agrees that, in consideration of the services to be rendered to the patient, he/she agrees to pay The Counseling and Diagnostic Center of Woodfield, Ltd. in accordance with the regular fees and terms as outlined.
3. Any insurance claim submitted to an insurance carrier that is denied due to a billing error will be corrected and resubmitted at the expense of The Counseling and Diagnostic Center of Woodfield, Ltd. Any insurance claim denied due to a patient/guarantor error (incorrect policy information, etc.) will be subject to a claim denial fee in the amount of $5.00 per claim. If denied claim is correctable and payable upon resubmit the denial fee will be waived. Claim will be subject to a claim resubmit fee in the amount of $2.50 per claim.
4. Should the account be referred to an agency or attorney for collection, the undersigned will pay for all attorney fees and will be responsible for all collection expenses. The undersigned shall also be held responsible for all interest after 60 days, at the rate of 1.5% of the unpaid monthly balance.
5. In the instance of failure to comply with these obligations, each consents to the disclosure of their identity and other necessary information relating to the services rendered to the patient by the attending counselor, clinic, or attorney for the purpose of enforcing the patient's or guarantor's obligations to the attending counselor or collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient's confidentiality by the attending counselor/psychotherapist or clinic.

I authorize The Counseling and Diagnostic Center of Woodfield Ltd. to release any information including the diagnosis and the records of any treatment of examination required to the above named patient during the period of such care to the third party payor for the sole purpose of obtaining payment for services rendered to the patient by The Counseling and Diagnostic Center of Woodfield. Ltd.

I authorize and request that my insurance company pay directly to The Counseling and Diagnostic Center of Woodfield, Ltd. all insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual fee for service billed. I agree to be responsible for all fees for service not paid by my insurance carrier for services rendered on behalf or myself, or my dependents, unless prohibited by contract.

I have read and understand the above information and agree to these conditions.

X_____/_____/_____

Signature of patient or responsible party/guarantor Date

X_____/_____/_____

Signature of witness Date