

Initial Intake Form

Park Ridge Psychological Services
36 Main Street, Ste. 106
Park Ridge, IL 60068

Patient Information	Insured Information (if different than patient)
Patient's Name: _____	Insured Name: _____
Patient's Birthdate: _____	Insured's Birthdate: _____
Address: _____	Address: _____
City, Zip: _____	City, Zip: _____
Home Phone: _____	Home Phone: _____
Other: (Circle) Work Cell : _____	Other: (Circle) Work Cell : _____
Best place/# to reach: Home ___ Cell ___ E-mail ___	Best place/# to reach: _____
E-mail: _____	E-mail: _____
	Insured's Employer: _____
How would you like benefit information sent? Mail ___ E-mail: ___ Home Phone: ___ Fax: ___ (_____)	

Insurance Company Information
Name Of Insurance Company and Plan: _____
Insured's ID Number (Include Alpha Prefix): _____ Insured's Policy #: _____

Credit Card Use: (Circle) Visa Mastercard
Card # _____ Expiration Date: _____ Security Code (3 digits): _____
Cardholder's signature authorizing charges on this account: _____
Note: Missed sessions will be charged the full fee on the credit card.

Office Use Only

Insurance Company Phone #: _____

Yearly Deductible: \$ _____ Amount of deductible met so far: \$ _____

Co-pay for Outpatient Mental Health: \$ _____ Maximum visits per year: _____

Authorization required? Number to call for pre-authorization: _____

Address to submit Mental Health Claims to _____

Default CPT: _____ Default Dx.: _____