1020 Milwaukee Ave
Suite 235
Deerfield, Illinois 60015
ph (847)436-6967
fax (847)787-5249
website: attentiontowellness.com

CLIENT CONFIDENTIAL INFORMATION

Patient name: _____ Today's date: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Marital status: _____

Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____

Email address:_____

Attention to Wellness, LTD would like to send you emails periodically with general tips and self-help information for wellness.

I give permission for Attention to Wellness to send me such emails: _____ Yes _____No

HEALTH INSURANCE INFORMATION

Primary insurance company: _____

Insurance ID #_____ Group #_____

Name of insured (policy holder):_____

Policy holder's date of birth: _____

Policy holder's address: _____

Policy holder's home phone _____ Cell phone: _____

Policy holder's relationship to patient ____self ____spouse ____ parent ____ other_____

Secondary insurance Company _____

Insurance ID #_____ Group #_____

Name of insured (policy holder):_____

Policy holder's date of birth: _____

Policy holder's relationship to patient ____self ____spouse ____ parent ____ other_____

ADDITIONAL CLIENT INFORMATION & CONSENT TO BILL INSURANCE

In case of emergency, please contact: _____

Phone: _____

Referred by: _____

Psychiatrist's name (optional): _____

Current physical health: _____Good _____ Fair _____Poor

Current or chronic illness: _____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES:

Name _____Relationship to patient _____

_____The below signature indicates that all insurance benefits are assigned to Attention to Wellness, LTD.

_____The below signature allows Attention to Wellness, LTD to release necessary records to my insurance company to bill for this session.

Signature _____ Date _____

Please text or email a picture of the front and backside of your insurance card(s) to your Therapist prior to your appointment. Thank you.