CHICAGO PSYCHOLOGICAL SERVICES

Patient's Name_____Date Of Birth_____( )Male ( )Female

Address_____Apt_____Age_____

City_____State_____Zip_____Marital Status_____

SS#_____Email_____

Home Ph # ( )_____ Best number to contact you:

Cell # ( )_____ ( )Home ( ) Cell ( ) Work

Work # ( )_____

Employer_____ Occupation_____

Primary Insurance_____ Secondary Isurance_____

Primary Insured_____ Primary Insured_____

Primary Insured DOB_____ Primary Insured DOB_____

ID #_____ ID #_____

Group #_____Group #_____

Credit Card ( ) Visa ( ) Master Card ( ) American Express

Credit card # _____ Exp. Date_____ CV_____

REASON FOR VISIT

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ASSIGNMENT AND RELEASE

I hereby give permission to Dr. Houck to administer treatment, as necessary for the diagnosis of my condition.

I hereby authorize payment directly to Chicago Psychological Services . I understand and acknowledge that I am financially responsible for the entire services provided for myself or the above names, regardless of insurance coverage.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____