

18 S. Fifth Street, Suite 202, Geneva, Illinois 60134 Office: **630-355-5280** | **cpsychservices.com** 

Welcome,

Please review, fill out and sign the attached information packet. I will need to make a copy of your insurance card, so please have it available. We will review any questions at the beginning of your appointment.

Thank you.

### **New Client Packet**

- 1. Patient Information Form\*
- 2. Private Practices Acknowledgment/ Signed Outpatient Services Contract\*
- 3. Checklist of Concerns Form\*
- 4. Health Information Form\*
- 5. Office Policies Signed Acknowledgement\*
- 6. Failed appointment/late cancellation policy\*
- 7. Credit Card Authorization Form\*
- 8. Appointment notification form

#### For office use only:

Admin/Intake Form Client Initial Consultation Intake Form

<sup>\*</sup>Signature required



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# **Patient Information**

Welcome! Please complete all spaces.			
First Name (patient):	MI:	Last: _	
Parent names (if patient is a minor):			
Legal Guardian (if patient is a minor):			
Home Address:			
City:		State:	Zip Code:
Telephone: Home:		Cell:	
Where may we leave a message?			<del>_</del>
Date of Birth (client):	-		
Age: Gender:	Marital Status:		
Who referred you to us?			
Primary Insurance Company (Circle):	BCBS	Aetna	Out-of-Network:
Name on Insurance Card:			
ID#:			Group #:
Insured's Address and Telephone (if differen	t from c	ient):	
Date of Birth:	_		
Secondary Insurance Company:			
Name on Insurance:			
ID#:			Group #:
Insured's Address and Telephone (if differen	ıt):		
Date of Birth:	-		
I hereby authorize Deanna K, Weiss, Psy.D. insurance company may request concerning to which I am entitled for expenses relative t responsible to said psychotherapist for charg	my servi o the ser	ces. I hereby vices received	assign Deanna K. Weiss, Psy.D., all monies d. I understand that I am financially
Signature of Patient or Legal Gu	ardian		 Date



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<b>D</b>	D	
Dear	Patient	•

If you would like to receive a reminder of your appointments, please indicate your interest by providing your email. All reminders will be discreet and only indicate the practice name, appointment date and time.

Please note that this notification is only a courtesy, and does not affect our cancellation policy.

NAME:		
EMAIL:		



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# PRACTICE ACKNOWLEDGEMENT

# ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, failed appointment/late cancellation policy.	HIPPA form, Outpatient Services Contract and the	
Name:	Birthdate:	
Signature:		
Date:		