

REGISTRATION FORM

Linda Levi, LCPC
1580 N. Northwest Hwy, Suite 117
Park Ridge, IL. 60068

CLIENT INFORMATION:

Client Name: _____ Date of Birth: _____

Billing address: _____ Gender: M / F

_____ Social Security# _____

Home phone#: _____ okay to call? Y / N

Cell phone#: _____ okay to call? Y / N

Marital status: (circle one) Single Married Coupled Widowed Separated Divorced

IF YOU HAVE YOUR INSURANCE CARD WITH YOU WE WILL MAKE A COPY OF THE CARD. YOU DO NOT NEED TO FILL OUT THE INFORMATION BELOW.

INSURANCE INFORMATION:

Primary Insurance carrier: _____ Insurance Phone No.: _____

Insurance Claims mailing address: _____

Subscriber Name: _____ Subscriber's SS # _____ DOB: _____

Identification No.: _____ Group No.: _____ Co-Pay \$ _____

Client's relationship to subscriber: (circle one) Self Spouse Child Partner Other

SECONDARY INSURANCE INFORMATION: (IF APPLICABLE)

Secondary Insurance carrier: _____ Insurance Phone No.: _____

Insurance Claims mailing address: _____

Subscriber Name: _____ Subscriber SS # _____ DOB: _____

Identification No.: _____ Group No.: _____ Co-Pay \$ _____

Client's relationship to subscriber: (circle one) Self Spouse Child Partner Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Linda Levi, LCPC or Tri-County Medical Billing staff to release any information required to process my claims.

Signed: _____ Date: _____