lifeworks
PSYCHOTHERAPY CENTER

3139 N. Lincoln Ave.
Suite 220
Chicago, IL 60657

120 W. Madison
Suite 920
Chicago, IL 60602

8707 Skokie Blvd.
Suite 310
Skokie, IL 60077

simply aware, fully alive

(847) 568 1100

www.lifeworkspsychotherapy.com

Client Information

If seeking relationship therapy, please fill out one of these forms for each partner.

Your Name (as it appears on your insurance card): _____DOB _____

Preferred Name: _____ Your Preferred Pronouns: _____

Gender/Identify as: female male transgender gender non-conforming other _____

Relationship Status: single partnered open relationship poly married separated/divorced

widowed prefer not to answer other _____

Your Partner's Name _____ Your Partner's Preferred Pronouns:_____

Your Partner's Name _____ Your Partner's Preferred Pronouns:_____

Address: _____

_____Zip Code _____

Contact Phone # _____ cell work home Email _____

Would you like an email appointment reminder? yes no Number of days in advance: _____

Emergency Contact: _____ Relationship to you: _____

Preferred Pronouns: _____ Contact Phone # _____ cell work home

Please list all insurance carrier(s) and complete to the best of your knowledge:

ID # _____ (required) Policy/Group # _____

Effective Date: _____ (if not currently effective) Calendar Year Plan ? yes no

Deductible Amount: _____Deductible Amount Paid YTD _____ Out of Pocket Max _____

Co-pay Amount: $_____ Co-insurance %: _____ Pre-authorization Req'd? yes no

Responsibility, if there are two plans in effect: primary secondary

Do you have limitations on the number or type of sessions? Y N don't know

Complete this section for a second carrier, if you have one:

ID # _____ (required) Policy/Group # _____

Effective Date: _____ (if not currently effective) Calendar Year Plan ? yes no

Deductible Amount: _____Deductible Amount Paid YTD _____ Out of Pocket Max _____

Co-pay Amount: $_____ Co-insurance %: _____ Pre-authorization Req'd? yes no

Responsibility, if there are two plans in effect: primary secondary

Do you have limitations on the number or type of sessions? Y N don't know

I have an HSA (health savings account) or Flex account. Please provide a SuperBill monthly. yes no

Out of Network Provider:

____ I have insurance other than BCBS PPO, Blue Choice or Medicare.

Please provide a SuperBill for me: at each session monthly

If you have Medicare, please complete the following:

ID#_____ (required) Effective Date: _____

Secondary/Supplemental Insurance:

Insurer _____ ID # _____ Group # _____

This Section For Office Use Only

___ Psychotherapy Policies read & signed TX/CLIENT CODE _____ Circle one: IND REL

___ Client Consent read & signed

___ HIPAA Notice offered to client

___ Copy of each insurance card made

___ Photo ID copied

___ Supervision Acknowledgment read & signed (if needed)

Who should be recorded as the financially responsible party?
Does the client code accurately reflect the responsible party?
ENTER THE CLIENT CODE IN THE SPACE ABOVE

Diagnosis (ICD-10: F34.1(d) ; F41.1(a)): _____ Fee _____