innerVoice
Psychotherapy & Consultation

180 N. Michigan Ave.
Suite 531
Chicago, IL 60601
Phone: 312-620-1420
Fax: 312-345-8444
www.innervoicepc.com

Client Name: _____ **DOB:** _____ **Gender:** M / F
Social Security #:_____ **Marital Status:** S M W D
Address: _____
City: _____ **State:** _____ **Zip:** _____
If minor (under age 18), please write name of legal guardian: _____
Are bills to be sent to the above address? If different than the above address given please write responsible party name and address:

_____
_____
_____

Home Tel: (____) _____ **Ok to call/leave message?** _____
Work Tel: (____) _____ **Ok to call/leave message?** _____
Cell: (____) _____ **Ok to call/leave message?** _____
Email Address: _____ **Ok to email?** _____
Would you like to be added to our email list for events and newsletters? _____
Employer Name: _____ **City:** _____
How did you hear about us? _____

Insurance Information
(Primary)

Insurance Company Name: _____
Insurance Company Phone: _____
Claims Mailing Address: _____

_____

Subscriber Name: _____ **Subscriber DOB:** _____
Group Name/Number: _____ **Identification Number:** _____

Authorization Information/Notes: *(Office Use Only)**:***

Please read the following carefully and sign below:

I give permission to InnerVoice Psychotherapy & Consultation billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as copays, deductibles, and non covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed: _____ **Date:** _____