lifeworks
PSYCHOTHERAPY CENTER

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Suite 920
Chicago, IL 60602

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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 Pronouns: _____

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

gender expansive/diverse enby other _____

Relationship Status: single partnered open relationship polyamorous CNM married

separated/divorced widowed prefer not to answer other _____

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

Your Partner's Name _____ Your Partner's 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: _____

Contact's 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** ----------

TX/CLIENT CODE _____ Circle one: IND REL

___ Psychotherapy Policies read & signed
___ Client Consent read & signed
___ Credit Card Authorization read & signed
___ HIPAA Notice offered to client
___ Insurance card(s) copied
___ 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 _____

QUICK CLAIM INFO

If you complete an intake during the week but are not able to physically get the completed intake packet to Skokie by Wednesday morning, please add the following information into the Post-It in TheraBill. This will prevent any delays in processing the initial claims that result from poor fax transmission. **NOTE: You expected to add this info to TheraBill Post-it even if you have faxed the intake into Skokie.**

Client Name (as it appears on their insurance card)
Date of Birth
Address
Insurance Card ID (& Group # if present)
Diagnostic code
CPT Code
IND or REL