AIC Associates

Susan R. Smith, Ph.D.
Licensed Clinical Psychologist

205 Commerce Drive
Suite C
Grayslake, IL 60030

VM: (847) 604-1932
Office: (847) 543-8378
Fax: (847) 543-9424

CONFIDENTIAL CLIENT INFORMATION (PAGE 1 OF 2)

Welcome to my practice. Please fill out the following questions as completely as possible.
PLEASE PRINT OR WRITE LEGIBLY

Client's Name	Ms. Mrs. Mr. Last First Middle
Client's Address	Street
	City State: Zip Code:
Phone:	Home: ( ) Work: ( ) Cell: ( )
	Age: Birth date: Birth Place:
Education:	No. of Years: Degree(s): Field:
	Religious Background: Current Religion:
Spouse	Name: Age: Occupation: Years Married:
Children:	M F Name: age: / M F Name: age: / M F Name: age:

Marital Status:
- ▢ Single
- ▢ Married
- ▢ Separated
- ▢ Divorced
- ▢ Widowed
- ▢ Other

Father's Name: Age: Occupation:

Mother's Name: Age: Occupation:

Brothers and Sisters (including yourself) in birth order:	M F Name: age:	M F Name: age:
M F Name: age:	M F Name: age:	M F Name: age:

In your family was there a history of: ▢ Alcoholism? ▢ Substance Abuse? ▢ Mental Illness?
▢ Prolonged physical illness? What Kind?

Current Medications:

Significant medical problems:

M.D. Name: Last seen?

Have you had previous psychological/psychiatric care and/or counseling? ▢ Yes ▢ No If yes, give:

Name of clinician Degree/License Sessions from to

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders? ▢ Yes ▢ No
Details

CONFIDENTIAL CLIENT INFORMATION (PAGE 2 OF 2)

If insurance card is available to copy only complete the * items

*Client Name: *Client will: O Self Pay or O Use Insurance

* Client is: O Employed, O Part- time student , O Full-time student

*Name of Insured or Responsible party: * Social Security No.

*Relationship to Insured:
O Self
O Spouse
O Child
O Other

*Responsible party's billing address if different from Client: State: Zip Code: Phone

*Insured employed by: * Insured Member No. * Insured DOB:

Employer's address:

City: State: Zip Code: Phone:

Name of Insurance Company Group No: Plan Name:

Insurance company's billing address State: Zip Code: Phone

Mental Health Benefits:

*Deductible: * Co-payments and/or Co-Insurance

*Sessions Per Year: *Authorization #:

Initial Visit: Follow-up Visits: Late Cancellation/ Failed Appointment:

*Referral Source: Dx:

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT:
I hereby give authorization for payment of insurance to be made directly to Susan R Smith, PhD for services rendered. I understand that I am financially responsible for all charges not covered by insurance. If the balance should go to collections, I am responsible for attorney and collections fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree a photocopy of this agreement shall be valid as the original

I acknowledge that I will be charged the full session fee for late cancellation or failed appointment.

*________________________________ **Date** ________________
Signature

*________________________________ **Date** ________________
Parent or Responsible Party Signature

I have been given and agree to read the Agreement and HIPPA Notice Form.

*________________________________ **Date** ________________
Signature