The Glenbrook Therapy Center

Client Information Form

Name: _____ Date: ___/___/___

Address: _____ Home Phone: (_____) _____

_____ Mobile: (_____) _____

E-mail: _____ SSN (optional): _____

Date of Birth: ___/___/___ Marital Status: _____

Names of Members of Immediate Household:	Age	Gender	Relationship
_____	_____	❑ F ❑ M	_____
_____	_____	❑ F ❑ M	_____
_____	_____	❑ F ❑ M	_____
_____	_____	❑ F ❑ M	_____

Client: ❑ Employed Full Time ❑ Employed Part Time ❑ Full-Time Student ❑ Part-Time Student

Employer/School: _____ Job Title: _____

How long there? _____

Address: _____ Work Phone: _____ Ext.: _____

_____

Spouse: ❑ Employed Full Time ❑ Employed Part Time ❑ Full-Time Student ❑ Part-Time Student

Employer/School: _____ Job Title: _____

How long there? _____

Where did you hear about us? / Who referred you to us? _____

If by internet search, which search engine and search terms (if you recall): _____

Reason for this call: _____

_____

_____

How long has this been a problem? _____

_____

Previous therapy: _____

_____

Relevant medical condition(s)/treatment(s): _____

_____

Questions/Concerns/Expectations: _____

The Glenbrook Therapy Center

Fee Payment Procedures

We ask for payment at the time of each session unless you have made other arrangements with your therapist. You are responsible for submitting any insurance claims for fees paid. Your therapist will complete the provider's portion of claim forms or provide computer-generated claim forms on request. Clients covered by managed care plans are responsible for co-payment amounts, which are payable at the time of service. Please sign here to indicate that you understand and agree to these terms.

Signature: _____ Date: ___/___/___

Insurance Information

Name of Insured Party: _____

Date of Birth of Insured Party: ___/___/___

Client's Relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Insured's Information (if different than Client's):

Home Address: _____ Home Phone: (_____) _____

_____

❑ Employed Full Time ❑ Employed Part Time ❑ Full-Time Student ❑ Part-Time Student

Employer/School: _____ Job Title: _____

Address: _____ Work Phone: _____ Ext.: _____

_____

Insurance Company: _____

Address: _____ Phone: _____

_____

Program or Plan Name or Type: _____ Policy/Group number: _____

Insured's ID number: _____ Client's ID number (if different): _____

Authorization of Payment

I authorize payment of insurance benefits to myself or the named provider for professional services rendered by the Glenbrook Therapy Center.

Signature: _____ Date: ___/___/___

Release of Confidential Information to Insurers

I authorize the release of any confidential information necessary to process any insurance claim arising from therapy provided by the Glenbrook Therapy Center.

Signature: _____ Date: ___/___/___