Park Ridge Psychological Services

542 Busse Hwy.
Park Ridge, IL 60068

Patient Information:

Patient's Name:_____

Patient's Date of Birth:_____

Address:_____

City, Zip:_____ _____

Home Phone:_____

Cell :_____

E-mail: _____

Insured Information (if different than patient):

Insured Name:_____

Insured's Date of Birth:_____

Address:_____

City, Zip:_____ _____

Home Phone:_____

Cell :_____

E-mail: _____

Insured's Employer:_____

How would you like benefit information sent? Mail___ E-mail:___ Home Phone:___

Where and to whom would you like billing information sent? _____

In order to save paper and postage, may we send monthly invoices to the e-mail you provided? YES_____ NO_____

Insurance Company Information

Name Of Insurance Company and Plan:_____

Insured's ID Number (Include Alpha Prefix):_____ Insured's Policy #:_____

We require a credit card on file. Payment can be made via cash, check, credit card, or Zelle/QuickPay.

Credit Card: (Circle) Visa Mastercard AMEX

Card #_____ Expiration Date:_____ Security Code (3 or 4 digits):_____

Please sign to authorize the following charges on this account: _____

OFFICE USE ONLY

Default Dx.: Adjustment D/O Other: _____ Testing? YES / NO

Yearly Deductible: $_____ Amount of deductible met so far: $_____

Co-pay for Outpatient Mental Health: $_____ Maximum visits per year:_____