Highland Park Psychological Services

210 Skokie Valley Road Suite #12 | Highland Park | www.hppsychservices.com | (847) 915- 6078

INSURANCE INFORMATION FORM

Patient Information:

Patient's Name:

Patient's Date of Birth:

Address:

City, State Zip:

Home Phone:

Cell Phone:

Email:

Other:

Insured Information (if different from patient)

Insured's Name:

Insured's Date of Birth:

Address:

City, State Zip:

Home Phone:

Cell Phone:

Email:

Insured Employer

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

Where and to whom would you like billing information sent?

Would you like to receive invoices on a monthly basis? YES NO

If no, please specify what how often you would like to receive invoices?

In order to save paper and postage, may we send monthly invoices to the e-mail you provided? YES NO

If not, is there another e-mail address we may send invoices?

How do you prefer to pay your balances?

Check_____ Cash_____ Zelle/Chase (billing@prpsych.com)_____Credit Card*(3% additional charge) _____HSA Account/Credit Card*_____

*List Credit Card information below

Insurance Company Information:

Name Of Insurance Company and Plan:

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

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:

Highland Park Psychological Services

210 Skokie Valley Road Suite #12 | Highland Park | www.hppsychservices.com | (847) 915- 6078

Office Use Only:

Default Dx.: Other: Testing? YES / NO

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

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

Authorization required? Number to call for pre-authorization: