Register As a New Patient

Name *

First Name Last Name

Patient Date of Birth *

Email *

example@example.com

Patient or Guardian's Cell Phone *

Area Code Phone Number

Patient's Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Request A Therapist

- ○ Karen Butler-Cook
- ○ Ron Czub
- ○ Amanda Cichanowski
- ○ Kristina Labriola
- ○ Max Cook

Type of Services sought *

- ○ Individual Therapy
- ○ Marital Therapy
- ○ Family Therapy
- ○ Sports Performance Consulting and sports mental acuity
- ○ Other

Chief Complaint (insurance carriers ask for this information; choose most significant if more than one apply) *

- ◯ Depression
- ◯ Anxiety
- ◯ Attention problems
- ◯ Academic problems
- ◯ Work-related problems
- ◯ Childhood behavioral problems
- ◯ Legal problems
- ◯ Social or relationship problems
- ◯ Cognitive or developmental delays
- ◯ Autism Spectrum Disorder (Asperger's)
- ◯ Health-related problems/chronic pain
- ◯ Eating disorder
- ◯ _____

Who Referred you to us?

Marital Status *

Employment Status *

Emergency Contact Name and Phone Number *

Name of Insurance Company *

Policyholder Name *

Policyholder Address *

Policyholder Date of Birth *

Group ID Number *

Name of person responsible for medical bills (if different than patient)

Claim Address (back of card) *

Customer Service phone number (back of card) *

Parent with custody (if patient is a child)

Member ID Number *

I have read and agreed to OFFICE POLICY, CONSENT TO TREATMENT, AND PAYMENT OF SERVICES on the following page *

◯ Yes

Submit this form by filling it out completely and sending it to therapycenter1@msn.com

THE THERAPY CENTER
9031 W. 151st Street
Suite 102
Orland Park, IL 60462
Telephone: (708) 460-2111
Fax: (708) 460-9166
Email: Therapycenter1@MSN.com

NOTICE TO ALL CLIENTS

OFFICE POLICY

I. The Therapy Center no longer processes secondary insurance claims. If you have secondary insurance, you will be responsible for filing your insurance claim.

2. FEE POLICY:
- All fees/co-pays are due at the time of session.
- Any parent/guardian that accompanies a minor to session is responsible for the fee/co-payment
- A NSF (NON-SUFFICIENT FUNDS) fee of $25.00 will be applied for all returned checks.
- Only Cash or Money Order will be accepted after a NSF charge has occurred.
- A $65.00 fee will be charged for failed sessions or appointments cancelled IN LESS THAN 24 HOURS IN ADVANCE.
- If a session is failed, not cancelled in less than 24 hours, or a fee is not paid at the time of service; full payment for the services rendered is expected at the next appointment.
- If a client owes for an amount more than the agreed upon fee of one session, additional appointments will not be scheduled.
- Additional appointments will be scheduled upon the receipt of full payment for services.
- The Therapy Center has the right to forward any unpaid balances to a collection agency.

3. Crisis Call
- $25.00 (15 Minute Minimum)
- $25.00 Per Each Additional 15 Minutes

4. A state which indicates a session fee that has been processed toward a PER CALENDAR YEAR DEDUCTIBLE MUST BE PAID, IN FULL, 30 DAYS FROM THE DATE OF THE STATEMENT, unless other arrangements are made in advance.

5. Year-End Statements will be prepared for a $5.00 charge (paid in advance) for an account, which indicates a zero balance.

Please discuss any questions you may have with your therapist. Thank you for your cooperation.

The Therapy Center
9031 W. 151st Street
Suite 102
Orland Park, IL 60462

CONSENT TO TREATMENT AND PAYMENT OF SERVICES

I consent to and authorize the performance/administration of the following services:

1. Psychiatric Evaluation

2. Psychological Evaluation

3. Medical Management

4. Neuropsychological Evaluation

5. Individual Psychotherapy/Counseling

6. Other Mutually Agreed Upon Services

In consideration for these services I agree to pay when billed, and be individually and fully responsible or all costs and fees associated with the same.

I understand that information/results from these services is confidential. Information necessary to ensure payment for services may be released to the insurance company, managed care company, billing service, collection agency, or providers attorney or providers insurance company. No information will be released to anyone other than the above, unless the patient signs an appropriate release of information form, except when the law requires information to be disclosed, or in case of medical emergency. (e.g. imminent threat of harm to self or others, child abuse. or neglect).

Unless patient/guarantor has authorized assignment of insurance benefits, payment in full is expected at the time services are rendered. An assignment of benefits does not release the patient/guarantor from financial responsibility. If payment is not received within 45 days of final billing for any balance due, the patient/guarantor accepts responsibility to promptly pay the balance due along with all expenses incurred in collecting the balance.

I have received and read this agreement. I fully understand my rights and obligations and agree to be bound by them.