ATCF Institute
Helping You Discover Solutions
(847)436-6967 • private@atcfcounseling.com
1020 Milwaukee Ave. • Deerfied, IL 60015 • www.atcfcounseling.com

CLIENT CONFIDENTIAL INFORMATION

Patient name: _____ Today's date: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Marital status: _____

Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____

Email address:_____

The ATCF Institute would like to send you emails periodically with general tips and self-help information for wellness.

I give permission for The ATCF Institute to send me such emails:

_____ Yes _____No

HEALTH INSURANCE INFORMATION

Primary insurance company: _____

Name of insured (policy holder):_____

Policy holder's date of birth: _____

Policy holder's address: _____

Policy holder's home phone _____ Cell phone: _____

Policy holder's relationship to patient ____self ____spouse ____ parent ____ other___

Secondary insurance _____ #_____

ADDITIONAL CLIENT INFORMATION & CONSENT TO BILL INSURANCE

In case of emergency, please contact:

_____ Phone: _____

Referred by: _____

Psychiatrist's name (optional): _____

Current physical health: _____Good _____ Fair _____Poor

Current or chronic illness: _____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES:

Name _____Relationship to patient _____

_____The below signature indicates that all insurance benefits are assigned to Adult Therapy and Cohesive Families Institute.

_____The below signature allows the Adult Therapy and Cohesive Families Institute to release necessary records to my insurance company to bill for this session.

Signature _____ Date _____