Registration

Person to be Seen:

Date: ________________ Date of Birth: ________________ SS#: ____________________

Name: ____

Address: ____

Home Phone: __________________ May we leave a message at this number: _____________

Cell Phone: ____________________ May we leave a message at this number: _____________

Email Address: ____

Responsible Party Information

Date: ________________ Date of Birth: ________________ SS#: ____________________

Name: ____

Address: ____

Home Phone: _____________ Work Phone: ______________ Cell Phone: ______________

Insurance Information

Insured's Name: _____________________________ Relationship to Patient: _______________

Employer's Name: ___________________________ Occupation: _________________________

Insurance Company: _____________ Ins Co. Phone: _____________ Ins Co. Zip: _________

Insurance ID#: _______________________________ Group/Plan #: ______________________

Miscellaneous

Emergency Contact: ___________________________ Relationship to Patient: _______________

School Name (if Minor): _______________________ Grade: ____________________________

General Information

The reason for seeking treatment: ____

For Office Use Only:
DX: ___________ **Session Fee:** _____________ **Therapist:** ________________________________

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Who referred you here: ____

People living in the household (name, ages, relationship to the patient): ____________________

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Marital Status: ___________ Occupation: ______________ Yrs of schooling completed: _____

Current Doctor/Contact Info: ____

Office / Hospital: ____

Medical Conditions: **When diagnosed:**

____ ______________________

____ ______________________

____ ______________________

____ ______________________

Current Medications/Dose/Side Effects Experienced:

____ ______________________

____ ______________________

____ ______________________

I understand that I have, by signing below, full obligation to pay for services rendered, regardless of insurance reimbursement. I understand that if Dr. Steingraber is an in-network provider with my insurance she will submit billing on my behalf. Nonetheless, all copays and deductibles are my full responsibility. I also understand that should Dr. Steingraber be an out-of-network provider that I am responsible for

submitting claims to insurance should I wish to seek reimbursement. I also acknowledge that I am responsible for all fees associated with collections for payment of this account

My signature also indicates, that I have been given a chance to review HIPPA guidelines (Privacy Practices) and fee policies. Should I have questions I understand I may contact Karla Steingraber, Psy.D., 333 Skokie Blvd, Suite 114, Northbrook, IL 60026; 847-778-3997.

Signature: ____ Date: __________________________

Witness Signature: ______________________________________ Date: _________________________

Credit Card on File:

I understand that my credit card or debit account will be charged for any fees uncollected after 30 days.

Signature:

____

Credit Card Account #: ____

Expiration: ________________ **CVV/Security Code:** (typically on back of card): _______________

Billing Address and Zip Code associated with the Credit/Debit Card:

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Permission for treatment of minor: *(Skip if not applicable)*

If divorced please indicate custody arrangement: ____
(if joint custody, both parents' signatures must be present below)

Parent Signature: **Parent Signature:**

____________________________________ ____________________________________