Hoffmann Ψ Burchett Psychological Services, LLC
205 N. Williamsburg Drive, Suite F, Bloomington, IL 61704

Client Contact Information (Adult)

Today's Date: _____ **Referral Source:** _____

Name(s):_____ **DOB:** _____

_____ **DOB:** _____

Address: _____

Cell Phone: _____ **Email:** _____

**Unless otherwise noted, all phone numbers/emails listed will be considered acceptable for contacting you and/or leaving messages regarding treatment, appointments, and/or billing. If you do not desire communication through any of the above numbers, please indicate this.

Employer(s) :

_____

Occupation: _____ **Highest Level of Education:** _____

If you would like appointment reminders, please circle preferred format:

HOME TEXT (cell phone: _____) EMAIL: _____
(if different than above)

In addition to appointment reminders, you have the option to access online services in order to schedule appointments, update your insurance information, complete biographical information, and/or contact your provider by secure email.

If you are interested, please provide the user name (under 15 characters). A password (your last name and the current year) will be temporarily provided in order to allow access to the system. You will need to log in and change the temporary password to allow for ongoing accessibility.

User Name: _____ **Password:** ____**Last NameYear**_____

<u>If using insurance, please provide your insurance card to be copied</u>

Insurance Plan _____**Insured's ID#** _____

Group # _____ **Insured's Employer:** _____

<u>*If the client is not the Insurance Subscriber:</u>**

Name of Subscriber: _____ **Date of birth (Subscriber):** _____

Relationship to Client: _____ **Subscriber's Employer:** _____

Do you have a second insurance plan? No _____ Yes _____

Name of Insured: _____ Insured's DOB: _____

Insurance Plan _____ Insured's ID#_____Insured's Policy Group# _____

Other Insured's Employer: _____

Name/Address of Person responsible for payment (if different than client):

_____

_____

Credit Card Information:

Please circle Credit Card type and complete the Information requested below in order to authorize payment on accounts with an outstanding balance of over 30 days:

Visa MasterCard American Express Discover

Cardholder's Name: _____

Account Number: _____ Expiration Date (mm/yr) _____

CVV (3 or 4 digit number): _____

Cardholder's Signature (to be kept on file): _____ Date: _____

Emergency Contact

Name: _____ Relationship to client: _____

Phone number(s): _____

Name of Primary Physician: _____ Date of last physical: _____

Name of Psychiatrist (if applicable): _____

Name(s) of other Healthcare Providers (if applicable): _____

All of the above information is considered confidential within the bounds outlined in the Guidelines for Psychotherapy Services and Informed Consent agreement. Thank You.