PRA Perakis, Resis, Woods & Associates

PRA Behavioral LLC
1701 E Woodfield Road Suite 1000
Schaumburg, IL 60173-5113
Phone: 847-240-2211 | Fax: 847-240-2418

CLIENT INFORMATION FORM

Patient Name: _____ Appointment Date: _____

Preferred Name: _____ Birth Date: _____

Age: _____ Gender (Per Insurance): _____

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ None

Current Gender Identity: ☐ M ☐ F ☐ Non-binary

Address: _____

All statements and office correspondences will be sent to the above address unless otherwise indicated below.

Please check the numbers /methods of contact that you consent to leave a message:

☐ Home Phone: _____ ☐ Cell Phone: _____

☐ Email: _____ Patient's SS#: _____

Other Numbers: ☐ Name: _____ Phone: _____

☐ Name: _____ Phone: _____

Race Group: Select 1 Other Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated ☐ Single

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Disabled ☐ In School

Student: ☐ FT ☐ PT ☐ Not Student Ethnicity: ☐ HISPANIC ☐ NON-HISPANIC

Emergency Contact Name: _____ Phone: _____

Email: _____ Relationship: _____

IF MINOR: Mother's Name: _____ Father's Name: _____

Name(s) of all legal Guardian(s): _____

Phone Number: _____

Client lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Self ☐ Spouse ☐ Significant Other

☐ Friends ☐ Other Relative ☐ Other: _____

PLEASE COMPLETE ALL SECTIONS

*****PLEASE REVIEW***** **BY SIGNING THIS LINE, I AGREE TO TRAVEL TO MY PHYSICIANS' LOCATION, ONCE TELEHEALTH IS NO LONGER AN OPTION OR SHOULD THE PHYSICAN REQUIRE ME TO COME TO THE OFFICE FOR TREATMENT.** ***You also MUST be in a CONFIDENTIAL area during Telehealth Session.***	Signature: _____

Who referred you to the provider you are seeing today? _____

Do you want your clinician to communicate treatment information with your Primary Care Physician (PCP)? ☐ YES ☐ NO

IF YOU CLICK "YES" YOU MUST COMPLETE THE EXCHANGE OF INFORMATION FORM

(Your PCP is your Internist, Pediatrician or Family Physician, not your Psychiatrist.)

If you want information shared with other outside professionals, family or agencies please let your MD/Therapist know.
Please note, no information will be shared with any NON PRA professional, family or agency without your written consent.

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CLIENT INFORMATION FORM - PAGE 2

CREDIT CARD ON FILE IS REQUIRED FOR TELEHEALTH AND SELF PAY SESSIONS

Financial Responsible Party: ☐ Patient ☐ Insured Person (*Other than patient*)_____

☐ Other: _____

Patient's relationship to the policy holder: ☐ Self ☐ Spouse ☐ Child

Identify Other: _____

Insured person's information:

Insured Person/Responsible Party Name: _____

☐ Address same as patient (Where statements are mailed)

Address: _____

Home Phone: _____ Work Phone: _____ Ext _____

Insured Date of Birth: _____ Email: _____

Insurance Company: _____ ☐ HMO Site #_____ ☐ PPO ☐ POS

Insured ID#: _____ Insured SS#: _____

Group/Plan #: _____ **Insurance Co. Phone:** _____

Employer of policy holder: _____ Insurance effective date: _____

☐ Self Pay - I understand visits will not be billed through insurance by PRA.

Do you have a Secondary Insurance? ☐ YES ☐ NO **If YES, please give a copy to this office.**

Secondary Insurance Company Name: _____

Second Insurance ID#: _____ Second Insurance Group # _____

Insured Person: _____ Insured Date of Birth: _____