

PRA Behavioral LLC

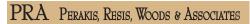
1701 E Woodfield Road Suite 1000 Schaumburg, IL 60173-5113 Phone: 847-240-2211 | Fax: 847-240-2418

CLIENT INFORMATION FORM

Patient Name:	Appointment Date:			
Preferred Name:	Birth Date:			
Age:	Gender (Per Insurance):			
Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Non	e			
Current Gender Identity:				
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 Marital Status: 🔲 Mar	ried □ Divorced □ Widowed □ Seperated □ Single			
Employment Status: ☐ Employed ☐ Unemployed ☐ Reti	red □ Homemaker □ Disabled □ In School			
Student: □FT □PT □Not Student	Ethnicity: ☐ HISPANIC ☐ NON-HISPANIC			
Emergency Contact Name:	•			
Email:				
	e: Father's Name:			
Name(s) of all legal Guardian(s):				
Phone Number:				
Client lives with:				
PLEASE COMPLETE ALL SECTIONS				
PLEASE REVIEW BY SIGNING THIS LINE, I AGREE TO TRAVEL TO MY PHYSICIANS' ONCE TELEHEALTH IS NO LONGER AN OPTION OR SHOULD THE REQUIRE ME TO COME TO THE OFFICE FOR TREATMENT. You also MUST be in a CONFIDENTIAL area during Telehealt.	LOCATION, PHYSICAN 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)? 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 F	Person (Other than patient)	
	☐ Other:		
	Patient's relationship to the	policy holder: Self Spouse	☐ Child
Insured person's info			
Insured F	Person/Responsible Party Name: _		
☐ Addre	ss same as patient (Where statem	nents are mailed)	
Address:			
Home Ph	none:	Work Phone:	Ext
Insured I	Date of Birth:	Email:	
Insurance Company:			PPO D POS
Insured I	D#:	Insured SS#:	
Group/Pl	lan #:	Insurance Co. Phone:	
Employe	r of policy holder:	Insurance effective date:	
☐ Self Pay - I understan	nd visits will not be billed through	insurance by PRA.	
Do you have a Seconda	ry Insurance? ☐ YES ☐ NO	If YES, please give a copy to this	office.
Secondary Insurance Co	ompany Name:		
Second I	nsurance ID#:	Second Insurance Group #	
Insured F	Person:	Insured Date of Birth:	