Ambre Associates, LLC
1920 Waukegan Rd. #200
Glenview, Illinois 60025
847-729-3034

Patient Information Form

Patient Name: ____

If minor child – Parent's Name: _________________________

Address: ____

City:__________________State:____________Zip:__________

Home Phone: _________________________ Y/N OK to leave message

Work Phone: _________________________ Y/N OK to leave message

Cell Phone: ___________________________ Y/N OK to leave message

Email Address: ____

Patient's Social Security #: _________________________

Patient's Date of Birth: ___________________

Referral Source:____________________________

If Applicable:

Name of Insured: __________________________________

Social Security # of Insured: ___________________________

Date of Birth of Insured: ____________________

Employer of Insured: ________________________________

Signature: __________________________________

Office Use Only

Intake Date: __________ Closed: ______________

Reopen Date:__________ Closed:______________

Dx:_________________

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Patient Agreements and Authorizations

Consent For Treatment: I hereby consent to the treatment provided the mental health professionals associated with Ambre Associates, LLC. I authorize the mental health care services deemed necessary or advisable by my caregiver to address my needs. I realize that no particular outcome is guaranteed as a result of my consent to receive treatment by Ambre Associates, LLC. (______) Please initial in space.

Authorization For Release of Personal Health Information: I authorize the use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the provider's business. I authorize Ambre Associates, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Ambre Associates, LLC may release objective information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. This section does not provide consent for the release of my clinical records. Additional specific consent must be obtained for that purpose. (______) Please initial in space.

Payment Guarantee/Collection Fee: I understand that I am financially responsible to Ambre Associates, LLC for payment of session fees at the rate of $175 per session for a 55-minute session (45 minutes for children). I understand that should my overdue account be referred to a collection agency; I will be responsible for the costs associated with collection, including reasonable attorney's fees. (_____) Please initial in space.

Privacy Policy: I acknowledge having reviewed and been offered a copy of Notice of Privacy Policies and Clients Rights Statement. My rights include the right to see a copy of my record, to limit disclosure of my health information, and to request an amendment to my record, as explained in the Policy. My right to make a complaint and file a grievance under Illinois law has also been explained. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Ambre Associates, LLC has already made disclosures with my prior consent. (____) Please initial in space.

______________________________	______________________	__________
Patient or Authorized Person Signature	Relationship to Patient	Date

______________________________	__________________
Witness Signature	Date