



Youth Services of Glenview/Northbrook

Client Information + Payment Form

Client + Parent/Guardian Contact Information:

Client Name: _____

Client Date of Birth: _____ Client Age: _____

Client Gender Identity: _____

Client Racial/Ethnic Identity: _____

Client Cell Phone Number: _____

Client E-mail Address: _____

Residence Street Address: _____

Residence City/State/Zip: _____

Residence Phone Number: _____

Parent/Legal Guardian:

Name / Relationship: _____

Phone Number Cell: _____

Phone Number Work: _____

E-mail: _____

Parent/Legal Guardian:

Name / Relationship: _____

Phone Number Cell: _____

Phone Number Work: _____

E-mail: _____

Emergency Contact (*other than parents/guardians listed above*):

Name / Relationship: _____

Contact Phone Number: _____

Referral Information:

Who told you about and/or referred you to Youth Services?

Insurance Company: _____

Friend/Acquaintance: _____

Doctor/Provider: _____

School staff: _____

Online Search

Other: _____

Client Medical Information:

Primary Care Physician/Practice Name: _____
Primary Care Physician Phone Number: _____
Current Medications (Dose, Frequency): _____
Prescribing Physician Name: _____
Prescribing Physician Phone Number: _____
Medical/Dietary Allergies and/or Conditions Limiting Activity: _____

Billing Information:

Who is responsible for payment?

Name(s): _____
Relationship to Client: _____
Street Address(es) (if not already listed above): _____

Phone Number(s) (if not already listed above): _____

Payment Information:

Will you be using your insurance?

No.

My agreed-upon private pay fee for intake, sessions, and missed sessions/late cancellations is \$_____.

Yes. *Please provide a copy of your insurance card.

Insurance Provider: _____
Insurance Provider Phone Number: _____
Insurance Group ID: _____
Insurance Member ID: _____
Insurance Plan Effective Date: _____
Name on Insurance ("Insured"): _____
Insured Date of Birth: _____ Insured Sex: _____
Insured Street Address + Phone Number (if not already listed above): _____

Referring Physician (if applicable): _____