

Chicagoland Cognitive Assessment Center, LLC
1300 W Belmont St Suite 205
Chicago, IL 60657

PATIENT INFORMATION

Last Name _____ First _____ MI _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email Address _____
Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes ☐ No ☐
Gender as enrolled with insurance company _____ Female _____ Male _____ Language Preference _____
Date of Birth _____ Age _____ Preferred Pronouns _____
Race: ___Asian ___ American/Alaskan Indian ___ Black/African American ___ Hawaiian ___Other/Unk ___White ___Declined
Ethnicity: ___Hispanic / Latino ___Non Hispanic /Non Latino ___Declined

GUARANTOR INFORMATION

**LEGAL GUARDIAN, OR WHOMEVER BRINGS IN MINOR CHILD OR INCAPACITATED ADULT,
MUST COMPLETE THIS SECTION**

Last Name _____ First _____ MI _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email Address _____
Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes ☐ No ☐
Date of Birth _____ Age _____ Language Preference _____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Signature of Patient OR Guarantor (if patient is a minor or incapacitated adult) _____ **Date** _____

Medicare Authorization and Assignment of Benefits: (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature _____ **Date** _____

COPY OF INSURANCE CARD MUST BE INCLUDED