KENNETH GATES AND ASSOCIATES
8600 US Rt. 14, Suite 110
Crystal Lake, IL 60012

Client Information

Last Name: _____

First Name: _____

Middle Initial: _____

Home Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Cell Phone: _____

Birth date: _____ Age: _____ Sex☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W

Email Address: _____

How were you referred to our practice? _____

_____

Guarantor, If Other Than Client

The Parent/guardian requesting services for a child, and signs the authorization for treatment on the first visit, is the responsible payor. If payment of the account is to be someone other than the authorized signature, we need a signed letter stating that this individual does accept responsibility for payment of the account.

Last Name: _____

First Name: _____

Home Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Birth date: _____ Age: _____ Sex☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W

Relationship to Client: _____

Email Address: _____

Insurance Information

PRIMARY:

Insurance Company: _____

Mental Health Carrier: _____

ID #: _____ Group #: _____

Name of Insured: _____

Relationship to Client: _____

Birth date: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Please be advised, we will submit to your insurance company on your behalf however it is the client's responsibility to verify coverage and benefits for counseling services.

SECONDARY (If Applicable):

Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____

Relationship to Client: _____

Birth date: _____

Social Security #: _____

Contact Phone: _____

For Office Use Only

Treating Clinician: _____

Primary Diagnosis: _____

Please continue on the back

Authorization to Release Information & Assignment of Benefits

Kenneth Gates and Associates (the practice) may disclose all or part of this client's records to any insurance company or association, either by mail or electronically, as may be necessary for the completion of all practice claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records. I understand that the information to be release may include information pertaining to mental or psychological related conditions and/or drug or alcohol abuse. A copy of this shall be as valid as the original.

I hereby authorize payment to Kenneth Gates and Associates benefits herein specified and otherwise payable to me for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. I hereby agree that in the event that medical coverage is not sufficient to apply to the indebtedness incurred, and should there be any money over and above that is necessary to pay this debt, I agree that said practice may apply coverage against any which is owed by myself, my spouse or legal dependents of myself or spouse at the time, to the practice. I hereby transfer all interest in and title to my reimbursement monies from my insurance company to the practice.

Client (age 13 & Older): _____ **Parent/Guardian:** _____

FINANCIAL POLICIES

Fee For Service:

- Payment of fees, co-pays and/or co-insurance is expected at the time of service
- We accept cash, credit cards and/or checks.
- The balance on all accounts is due in full within 30 days from the billing date. A $5 late fee may be applied to your account if the balance is not paid within the specified time.
- Returned checks – if a check is returned to us as unpaid by your bank, we may apply a $25 fee to your account.
- **MISSED APPOINTMENT/LATE CANCELLATION – the entire fee for sessions missed or cancelled less than 24 hours in advance may be charged to your account.**

Insurance

- This practice will submit insurance claims as a courtesy to you, however, it is your responsibility to verify coverage and benefit level. Additionally, this practice will not be responsible for disputed claims.
- Insured clients are expected to take care of their co-payment at the time services are rendered.
- Professional services rendered are charge to the client and not to the insurance company.
- "Usual and Customary Rates". Our practice is committed to providing the best treatment possible for our clients, and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.
- Information about your insurance coverage is not a guarantee of benefits. Actual benefits are determined by your insurance carrier when a claim is processed. Some plan exclusions and limitations may apply. Although we may have contacted your insurance and/or managed care company, it is your responsibility to pre-certify your initial visit and to know your plan's limitations, deductibles and exclusions.
- There are occasions in which mental health benefits are sub-contracted out by your insurance carrier, which may affect the reimbursement level of your treatment. It is your responsibility to know your plan's limitation, deductibles and exclusions.

I certify that the information provided on this form is correct to the best of my knowledge. I have read and understand the forgoing and duly authorize Kenneth Gates and Associates to execute the above and execute its terms.

_____ _____ _____

Client (age 13 & older) **Date** **Parent/Guardian**