V&R Behavioral Health Services
700 Ravinia Place - Orland Park, IL 60462
708.226.0010 P
708.226.0040 F

## Patient Registration Information

**Please provide copy of insurance card**

Date _____ Social Security #_____ Birth Date_____

Name _____
Last Name First Name Initial

Address _____Main Phone_____

City _____ State _____ Zip Code _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____Business Phone_____

Who referred you to our office? _____

In case of emergency, whom should we contact?_____Phone_____

If patient has seen any other mental health provider this year please give dates:_____

## Primary Insurance

Insured's Name_____
Last Name First Name Initial

Relationship to Patient _____Birth Date _____Social Security #_____

Address _____ Main Phone _____

City _____ State _____ Zip Code _____

Insured Employed By _____Insurance Company _____

Subscriber I.D. # _____Group # _____

## Additional Insurance (If Applicable)

Insured's Name_____
Last Name First Name Initial

Relationship to Patient _____Birth Date_____ Social Security #_____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Insured Employed By _____ Insurance Company _____

Subscriber I.D. # _____ Group # _____

## Assignment and Release

I hereby authorize payment directly to V&R Behavioral Health Services Ltd. I understand that I am financially responsible for all charges, whether or not paid by insurance, including collection costs incurred on unpaid balances, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required securing the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature(s) of Insured Date