

# CENTER FOR PSYCHOLOGICAL SERVICES, LLC

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[www.cps-chicago.com](http://www.cps-chicago.com)

Date \_\_\_\_\_ Name of Clinician \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Occupation \_\_\_\_\_ Work Address \_\_\_\_\_

Spouse's or  
Parent's Name \_\_\_\_\_ Address \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ Phone \_\_\_\_\_

Reason for consultation? \_\_\_\_\_

Who lives at home with you?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications, if any, are you taking? \_\_\_\_\_

Personal physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Previous professional contacts**

<b>Name</b>	<b>Address</b>	<b>Date</b>	<b>Reason</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED. While we will fill out the necessary insurance forms, our policy requires payment by the responsible party. Thank you.**

**Person responsible for payment:**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**I hereby authorize treatment for the patient named on the other side of this form and accept the responsibility for the charges incurred for this treatment or assessment, regardless of any other arrangements with third parties, including insurers.**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_