

Lisa Demos, MA, LCPC
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Ste. 410
Chicago, IL 60611

Intake Information

PATIENT'S
NAME _____

SPOUSE/CHILD
NAME _____

ADDRESS _____ CITY _____
ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK
PHONE _____

EMAIL ADDRESS _____ BIRTH
DATE _____

INSURANCE INFORMATION

INSURED'S NAME &
ADDRESS _____

INSURANCE COMPANY _____ MEMBER
ID# _____

GROUP # _____ INSURED'S
EMPLOYER _____

REFERRAL SOURCE _____ MARITAL
STATUS _____

CONFIDENTIALITY & EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for a) information you or your child report about physical or sexual abuse; then, by IL state law I am obligated to report this information to the Dept of Child and Family Services. b) information shared with your insurance company to process your claims c) where you sign a release to have specific information shared d) if you provide information that informs me that you are in danger of harming yourself or others e) I regularly seek clinical consultation and may discuss information about your case with another professional therapist who maintains the same level of confidentiality. If an emergency arises for which the client/guardian feels immediate attention is necessary the client/guardian understands they are to contact the emergency services in the community for those services.

Signature _____
Date _____

FINANCIAL/INSURANCE ISSUES: Fee for a 50 min session is \$110.00. Fees will vary if using insurance. As a courtesy, I will bill your insurance company if I am a member of your ins. company's panel. Copays are due at each session. **The client will be charged for appts cancelled or rescheduled with less than 24hrs notice. Sessions must be cancelled by phone and not email within that time.** In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your ins. co. denies payment for any reason, the client is responsible for the full fee. After 45 days any unpaid balance will be charged a fee of \$25 and will continue to be charged this fee every month until paid. If an overdue account is turned over to a collection agency, the client will be held responsible for any collection fees to collect the debt owed. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, payments please feel free to ask.

Signature _____ Date _____