Patient Name _____ Patient ID#_____ Patient SS#_____

Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
24402 W Lockport Street, Suite 215 ♦ Plainfield, IL 60544
630-621-5824

SECONDARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____
Insured's ID # _____Group/Policy #_____ Agency/Insurance Phone _____
Insurance Claims Mailing Address_____
City _____ State _____ Zip_____
Subscriber Name _____Subscriber Date of Birth_____
Co-pay amount _____Authorization # _____Number of Sessions Authorized _____

Are services pertaining to psychotherapy or testing? _____

A copy of your insurance card is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Agor Behavioral Health Services, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed $50.00. I understand that my insurance or EAP does not cover the cost of missed sessions.

_____ _____
Signature of Responsible Party Date