Bellosa Counseling, LLC
350 S. Northwest Highway, Suite 300
Park Ridge, IL 60068

Intake Cover Page: CHILD / TEEN

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. "Client" & "Patient" refer to person seeking services. "Member" refers to the person who carries the insurance policy.

Today's Date: _____

Client Name_____ Male Female
FIRST NAME MIDDLE LAST NAME CIRCLE ONE

Date of Birth_____ School_____ Grade_____

Parent #1_____
NAME ADDRESS

Parent #2_____
NAME ADDRESS (if different)

Client Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No
Parent #1's Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No
Parent #2's Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

Who is responsible for scheduling appointments? _____
How will client be getting to and from appointments? _____

INSURANCE INFORMATION (Please print clearly)

Member's Name_____ Member's Employer _____

Insurance Carrier_____ Group #_____ Plan_____

Member ID #_____ Member's Date of Birth_____

Your relationship to member: SELF CHILD/DEPENDENT

Therapist Assigned: _____ Supervisor (if applicable): _____

Date & Time of first scheduled appointment_____

Whom can we thank for your referral to Bellosa Counseling, LLC? PERSONAL REFERENCE_____

INTERNET: GOOGLE YAHOO INSURANCE COMPANY _____ OTHER_____

Emergency Contact (Name, Phone, & Relationship): _____

Session Fees & Copays: Due at the beginning of each appointment. Payment can be made by cash, check, or credit card. **Checks should be made payable to: Bellosa Counseling, LLC.**