Victoria Reid, PhD

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Burr Ridge, IL 60527
708-403-4055

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Decatur, GA 30030
678-954-5725

CONFIDENTIAL PATIENT INFORMATION

(*PLEASE PRINT*)

PATIENT INFORMATION

LAST NAME: ________________________________FIRST NAME: _______________________________________

ADDRESS: ____

CITY: ____STATE: ______ ZIP: ___________

PRIMARY PHONE: ___________________________ ALTERNATE PHONE: _________________________

EMPLOYER: _______________________________________ WORK PHONE: ___________________________

DATE OF BIRTH: __/__/ ___ SEX: M/F AGE: ______ MARITAL STATUS_____SS#_________________________

EMERGENCY CONTACT: ____

NAME & PHONE #

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:_____________________

ADDRESS: ___________________________

CITY:________________ST____ZIP__________

PHONE:________________________________

INSURED PERSON:________________________

ADDRESS:______________________________

CITY:_______________ST____ZIP__________

EMPLOYER:____________________________

SS#:__________________________________

ID#___________________________________

GROUP/POLICY#:________________________

SEX: M/F MARITAL STATUS___ D.O.B.__/__/__

RELATIONSHIP TO PATIENT:________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY:____________________

ADDRESS:______________________________

CITY:________________ ST____ZIP_________

PHONE:________________________________

INSURED PERSON:____________________ ____

ADDRESS:______________________________

CITY:_______________ST____ZIP__________

EMPLOYER:_____________________________

SS#:__________________________________

ID#___________________________________

GROUP/POLICY#:________________________

SEX: M/F MARITAL STATUS___ D.O.B.__/__/__

RELATIONSHIP TO PATIENT:________________

AUTHORIZATION TO RELEASE INFORMATION

I HEARBY AUTHORIZE VICTORIA REID,PH.D TO USE MY HEALTHCARE &DISCLOSE SUCH INFORMATION TO APPROPRIATE INSURANCE(S) & THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES & DETERMINING INSURANCE BENEFITS. I AUTHORIZE VICTORIA REID, PHD TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MEDICAL OR OTHER PERSONNEL WHO MAY PARTICIPATE IN MY CARE. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL I REVOKE SAID AUTHORIZATION BY GIVING WRITTEN NOTICE.

____

SIGNATURE OF PATIENT (PARENT IF MINOR) DATE

AUTHORIZATION OF PAYMENT TO PHYSICIAN

I HEARBY ASSIGN ALL INSURANCE BENEFITS TO VICTORIA REID, PHD ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY LIABLE FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE PAYMENT. VICTORIA REID, PHD DOES NOT WAIT FOR SETTLEMENTS FROM LAWSUITS. I AM RESPONSIBLE FOR PAYING FOR SERVICES.

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SIGNATURE OF PATIENT (PARENT IF MINOR) DATE