Victoria Reid, PhD

2021 Midwest Rd, Suite 200
Oak Brook, IL 60523
708-403-4055

160 Clairmont Ave, Suite 200
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.

_____
SIGNATURE OF PATIENT (PARENT IF MINOR) DATE