The Self-Care Path, LLC
1333 Burr Ridge Parkway, Suite 200
Burr Ridge, Illinois 60527
Phone: 708-429-0353
Fax: 386-263-8326
www.selfcarepath.com

PATIENT BILLING INFORMATION

If you are using EAP/ECP -you still must complete the billing/insurance information. Please write clearly and provide complete answers. Billing requires specific information. Thank you!

Patient's Full Name: _____

Patient's Address: _____
Street Number/Street City/State Zip

Significant Others' Names (Couples/Family Counseling): _____

Patient's Relationship to Insured/Payee: _____ Patient's DOB: _____

Patient's SocSecurity Number: _____ Patient is: ☐ Male ☐ Female; Identifies as: _____

Preferred Phone Number(s): _____

Patient's Email (to receive automatic appointment reminders): _____

Referral Information (Employer/Provider/EAP/Other): _____

Initial here if you will be filling out a *Release of Information* form for us to contact your physician: _____

INSURANCE INFORMATION, or CHECK HERE IF YOU ARE SELF-PAY ☐, and CHECK HERE FOR EAP/ECPs ☐

If you checked EAP/ECP, we will bill the EAP/ECP program for the sessions that they approve. All patients must have a debit/credit card on file; fee for service is due and will be charged on the day of service. Please fill out another copy of this form if you have secondary insurance information. First responder services are billed as The Self-Care Path, LLC.

Insured's Full Name (if different from above): _____

Insured's Complete Address w/ Zip Code: _____

Insured's Employer: _____ Occupation: _____

Complete Address: _____

Insured's SocSecurity Number (required for billing insurance): _____

Insured's DOB: _____ Insured is: ☐ Male ☐ Female; Identifies as: _____

Insurance Company: _____ Policy Number: _____

Group Number: _____ *First Appointment/Office Copied Insurance/I.D.: ☐

***Please bring your insurance card and identification card with you to your first appointment.**

The above information is true to the best of my knowledge. I authorize my EAP/ECP/Insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance, and that my card on file will be charged balances as they appear on my ledger. I also authorize my provider(s) and insurance company to release any billing information required to process my claims.

_____ Date: _____

Responsible Party Printed Name and Signature