

Marianne Tomlinson Therapy, LLC
1605 W. Wilson St., Suite 111
Batavia, IL 60510
630-337-6571

Client Name: _____ Date of Birth: _____
Billing Address: _____ Marital Status: S M W D Separated
City, State, Zip Code _____ Gender: M F
EmailAddress: _____
Okay to send correspondence or statements? _____
If minor (under age 18), please write name of legal guardian: _____
Home Phone: _____ Okay to call? _____
Work Phone: _____ Okay to call? _____
Cell Phone: _____ Okay to call? _____
Employer Name: _____ City: _____
How were you referred to us? _____

Primary Insurance

Insurance Carrier: _____
Phone Number: _____
Identification Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Insurance Claims Mailing Address: _____

Secondary Insurance

Insurance Carrier: _____
Phone Number: _____
Identification Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Insurance Claims Mailing Address: _____

Please read the following carefully and sign below:

I give permission to Marianne Tomlinson Therapy, LLC, and billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as copays, deductibles, and non-covered services, I will be responsible for. I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed: _____ Date: _____