



Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_ Patient SS# \_\_\_\_\_

Provider Name \_\_\_\_\_ Date \_\_\_\_\_

**Agor Behavioral Health Services, Inc.**

24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544  
6600 W. College Drive, Suite 101 ♦ Palos Heights, Illinois 60463  
630-621-5824

**SECONDARY AGENCY/INSURANCE INFORMATION (if applicable)**

Agency/Insurance Carrier Name \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Agency/Insurance Phone \_\_\_\_\_

Insurance Claims Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

Co-pay amount \_\_\_\_\_ Authorization # \_\_\_\_\_ Number of Sessions Authorized \_\_\_\_\_

Are services pertaining to psychotherapy or testing? \_\_\_\_\_

**A copy of your insurance or Medicaid card is needed at the time of service. Please read the following carefully and sign below.**

**Assignment of Benefits and Release of Information**

*I give permission to Agor Behavioral Health Services, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.*

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date