1443 W. Schaumburg Road
Suite 22E
Schaumburg, IL 60194

**Joseph N. O'Donnell & Associates**
CENTER FOR BIOFEEDBACK THERAPY
*Safe solutions for ADD, ADHD & related problems*

1400 East Golf Road
Suite 105
Des Plaines, IL 60016

**Please carefully read and fill -in ALL spaces below. Treatment can not begin until ALL patient information is submitted.**

**Today's Date:**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Patient's Last Name: First: Middle: | Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ |

| | | | | |
|---|---|---|---|---|
| Birth Date: | Age: | Sex: ☐ M ☐ F | Social Security Number: | Home/Cell Phone Number: |

| | | | |
|---|---|---|---|
| Street Address: (actual street, if different then mailing address) | City: | State: | ZIP Code: |
| Mailing Address: | City: | State: | ZIP Code: |

| | | |
|---|---|---|
| Occupation: | Employer: | Employer Phone Number: |
| Referred to office by: | Other family members seen here: | |

## INSURANCE/PAYMENT INFORMATION

**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST OR DOCTOR.)**

**IS THIS PATIENT COVERED BY INSURANCE? ☐ YES ☐ NO**

| | | | | |
|---|---|---|---|---|
| Person Responsible For Bill: | Birth Date: | Relationship to Patient: | Is this person a patient here? ☐ Yes ☐ No | Home/Cell Phone Number: |
| Address (if different): | | | City: | State: ZIP Code: |
| Occupation: | Employer: | Employer Address: | | Employer Phone Number: |

| | | | | | | |
|---|---|---|---|---|---|---|
| Primary Insurance | ☐ Blue Cross Blue Shield ☐ PPO ☐ HMO | ☐ Aetna | ☐ CIGNA | ☐ Self Pay | ☐ Other | _____ |
| Subscriber's Name: | Subscriber's S.S. Number: | Birth Date: | Group no.: | Policy Number: | Co-Payment: $ | |
| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other | | |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home/Cell Phone Number: | Work Phone Number:: |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Dr. Joseph N. O'Donnell & Associates, Inc.** or insurance company to release any information required to process my claims.

***Patient/Guardian signature*** ***Date***