Jennifer Levy, LCPC, CST, P.C.
737 North Michigan Avenue Suite 600
Chicago, Illinois 60611

Patient Information

Date:___________________________________

Patient's Name ______________________________________DOB:________Age:______

Male/Female/non-binary   Marital Status: Single Married Widowed Divorced Partner

Address: ____
Street   City   State   Zipcode
Phone: Cell____________________________________Other_______________________

Email Address: ____

Referral source: ____

Emergency Contact:____

CREDIT CARD INFORMATION

Credit Card Holder Name____

Billing Address____

Credit Card: Visa   MC   Other:_________Credit Card #___________________________

Expiration Date: _________________ CVS (3 digit code)____________________

I authorize Jennifer Levy, LCPC, CST, P.C. to bill the above credit card for this patient's appointments. I accept full responsibility for all charges for services rendered by Jennifer Levy, LCPC, CST, P.C. In addition, I authorize Jennifer Levy, LCPC, CST, P.C. to charge my credit card for cancellations that do not honor the practice's policies as well as missed sessions. I guarantee payment made with my credit card including renewed cards.

Print Name of
Patient:____Signature_________________
______

Signature of Card
Holder____Date:______________