Mason Kelly, LCSW
8553 S. Stony Island Ave., FL 1
Chicago, Illinois 60617

Client Name:_______________________________________ Date of Birth: _________________ Gender: M/F
Billing Address:____ Marital Status: S M W D
Zip Code: ______________________________________
E-mail Address:__________________________________ Okay to send correspondence or statements?__________
If minor (under age 18) please write name of legal guardian:____
Social Security Number:_____________________________________
Home Phone: _________________________ Okay to call?_________
Work Phone:__________________________ Okay to call?_________
Cell Phone:___________________________ Okay to call?__________
Employer Name: ____ City:____________________________________

Primary Insurance:

Insurance Carrier:____
Phone Number:____
Identification Number:_____________________________________ Group Number:__________________________________
Subscriber Name: _____________________________________Subscriber Date of Birth:____________________________
Subscriber Address: ____
Subscriber Phone: ____
Insurance Claims Mailing Address:____
____

Secondary Insurance:

Insurance Carrier:____
Phone Number:____
Identification Number:_____________________________________ Group Number:__________________________________
Subscriber Name:_____________________________________ Subscriber Date of Birth_____________________________
Subscriber Address: ____
Insurance Claims Mailing Address:____

____

Please read the following carefully and sign below:

I give permission to Mason Kelly, LCSW, 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:____