Linden Psychological Services

Paul Linden, Psy.D.

111 North Wabash, Suite 1422
Chicago, Illinois 60602-3068

(773) 879-2795

Client Registration Form

Contact Information:

First Name _____ Last Name: _____ Middle Initial ___

Address _____

City _____ State: _____ Zip Code _____

Home Phone: (____)_____ Work Phone (____) _____

Cell Phone (____)_____ Email _____

Social Security _____ Date of Birth _____

Employer _____ Occupation _____

Primary Care Physician:

Name _____ Phone (_____)_____

Address _____

City _____ State: _____ Zip Code _____

Emergency Contact:

Name _____ Phone (_____)_____

As a condition of your treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each client must be determined before treatment. Services performed without prior financial arrangements must be paid for in cash at the time of service. Clients who carry insurance understand that all services furnished are charged directly to the client and that the client is personally responsible for the payment of all services. This office cannot render services on the assumption that our charges will be paid by an insurance company. In consideration of the services renders to me by the Doctors and or their staff, I agree to pay for the services to said Doctor, or his assignees, at the time services shall be rendered. If payment balances should become delinquent and legal and or collection proceedings begin, I agree to pay all costs and attorney fees if suit were instituted hereunder. I grant my permission to you, or your assigns, to telephone me at my home, or at my work to discuss matters related to this form. I have read and understand the above conditions of treatment and agree to their content.

SIGNATURE: _____ DATE: ____/____/____