Susan M. Riley, LCPC, CADC
Naperville Clinical Associates
1755 Park Street
Suite 300
Naperville, IL 60563
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PLEASE COMPLETE ALL THE INFORMATION BELOW

Identifying Information:

First Name: ____________________ M.I.:____________Last: ______________________________

Address: ____
(street) (city) (state) (zip code)

Telephone: Home: __________________ Work: ______________Cell: ______________________

Where may I leave a message? Is a detailed message acceptable? _________________________

e-mail: ____________________ Date of Birth: _______________________ Age: _______

(circle, if desired) male female Relationship status:_____________________

Who referred you to my practice/Naperville Clinical Associates: ___________________________

Insurance Information:
Primary Insurance Company: ____

Insured's Name: ____
Insured's Address and Telephone (if different)
____

ID# __________________________________ Group # _______________________________

Is there someone you would like to authorize to speak with me regarding setting or cancelling appointments? If yes, name and telephone number:
____

I hereby authorize Susan M. Riley, LCPC, CADC, to furnish my insurance company with all information which the insurance agency may request concerning my present diagnosis. I hereby assign to Susan M. Riley, LCPC, CADC, all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to said clinicians for charges not covered by this assignment.

____ Date: __________________________
Signature of Patient or Legal Guardian