MONICA SCHMITT, PSY.D.
Clinical Psychologist
1755 Park Street • Ste. 300 • Naperville, IL 60563
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Please complete all information below.

Identifying Information:

First Name : _____ **MI:** _____ **Last:** _____

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

Telephone: Home: _____ **Work:** _____ **Cell:** _____

Where may we leave a message? _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

❑ **Male** ❑ **Female** **Relationship Status:** _____

Who referred you to my practice? _____

Insurance Information:

Primary Insurance Company: _____

Insured's Name: _____

Insured's Address and Telephone (if different): _____

_____

Insured's SS#: _____ **Date of Birth:** _____

ID #: _____ **Group #:** _____

Is there someone you would like to authorize at our office to speak with regarding scheduling and/or canceling appointments? If yes, name and telephone number: _____

I hereby authorize Monica Schmitt, Psy.D., to furnish my insurance company all information which the insurance agency may request concerning my present illness. I hereby assign to Monica Schmitt, Psy.D., all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to said doctor for charges not covered by this assignment.

_____ **Date:** _____
Signature of Patient or Legal Guardian