

# ADVANCED BEHAVIORAL CENTERS OF DUPAGE

Terrace Executive Center  
1 S. 376 Summit Ave., Court D, Unit 5B  
Oakbrook Terrace, IL 60181  
Dr. Burda: (630) 629-2700  
Physicians: (630) 629-6550  
FAX: (630) 629-6558

Hinsdale Professional Office Center  
501 W. Ogden Ave., Suite 1  
Hinsdale, IL 60521  
Therapists: (630) 986-0599  
Fax: (630) 986-1477

## INSURANCE AND BILLING INFORMATION

Primary Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Member I. D. # \_\_\_\_\_ Group No. \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_

Relationship of Insured to Patient: \_\_\_\_\_

Occupation and Employer of policy holder: \_\_\_\_\_

Address of policy holder: \_\_\_\_\_

---

*In order to keep our billing expenses down so that we will not have to raise our procedure charges to you, we are requesting payment for services at the time they are rendered. We ask that we can keep a credit card on file for you so that we can collect payment for services once your portion of payment is determined by your insurance company. Your information will be kept secure and transactions will only be made for services already rendered.*

**PAYMENT ACKNOWLEDGEMENT:** (circle one): American Express Visa Mastercard Discover Debit

CREDIT CARD NO : \_\_\_\_\_

NAME ON CREDIT CARD: \_\_\_\_\_

3 DIGIT CODE ON BACK OF CARD: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

I, \_\_\_\_\_, AUTHORIZE AN IMMEDIATE PAYMENT OF \_\_\_\_\_ (E.G., CO-PAYMENT) AGAINST THE ACCOUNT(S) LISTED ABOVE. I ALSO AUTHORIZE A CHARGE OF UP TO \_\_\_\_\_ (E.G., MAXIMUM PROCEDURE CHARGE, BALANCE DUE) AGAINST THE ACCOUNT(S) LISTED ABOVE IN ANTICIPATION OF SETTLEMENT ONCE THE FINAL PRICING AND EXPLANATION OF BENEFITS HAS BEEN ISSUED BY MY INSURANCE CARRIER.

---

Patient or Legal Guardian Signature

Date