Insurance Information

Client name: _____ Date of Birth _____

Client Address:

_____

_____

Client Phone #: _____ Alternate Phone #: _____

Name of Insured: _____ Date of Birth _____

Address of Insured: Insured's Phone # _____

_____

_____

Insurance Carrier_____

Address of Insurance Carrier:

_____

Insurance Phone # for Providers: _____

Insured's ID #: _____ Group Number _____

Relationship of Client to the Insured (Indicate one): Self____ Spouse _____Child ____ Other _____

Date of onset of this condition (required): Month ____Day ____ Year _____

Is condition related to: Employment? _____ Auto Accident? _____ or Other Accident?_____

Client is: Male _____ Female____ Single ____ Married ____ Employed_____ Student_____

Emergency Contact: Name _____

Address: _____

_____ Phone: _____

I am aware that insurance coverage is never certain until the payment is actually received. I am responsible for the balance if denial of payment is made by the insurance carrier and for any portion of the annual deductible of the policy. I will pay the co-payment at the time of service unless other arrangements are made.

I also understand that I am financially responsible for all appointments, unless I give 24 hours cancellation notice. I (not the insurance company) will pay a penalty fee equal to the fee for my session or $85 (for insurance clients) for appointments canceled with less than 24-hour notice, unless there is an emergency.

Signature _____ Date _____

I authorize the release of any medical, mental health or other information necessary to process claims and payment for medical benefits to the supplier of services.

Signature _____ Date _____

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To be completed by clinician:

Diagnostic code(s): _____

Clinician's name (print): _____