INSURANCE INFORMATION

Client Name _____ M__ F__ Birthdate _____/_____/_____

Address _____ Phone# (__ __ __) __ __ __ - __ __ __ __
_____ Alt Phone# (__ __ __) __ __ __ - __ __ __ __
_____ Marital Status S___ M___ W___ D___ Sep ___

Employment (Circle One) Full Part Not Employed Retired Active Military Retired Military
Student (Circle One) FT PT Name of School _____ Grade _____
Insurance Type (Please Circle One) Medicare Medicaid Tricare/Champus CHAMPVA Group Health Plan FECA;Blk Lung Other_____
Is Client's Condition Related To: Employment __Yes __No Auto Accident __Yes __No
Other Accident _____Yes ____No

COPY OF INSURANCE CARD(S) IS REQUIRED

Primary Insurance Company _____
Phone# (_____)_____
ID/Policy# _____ Group#_____

Is Pre-Authorization Required? Yes No
Auth# _____ Valid Dates_____ #of Visits _____
Is This Visit Part of An Employee Assistance Program (EAP)? Yes No
EAP# _____ Valid Date _____ # of Visits _____

Secondary Insurance Company _____
Phone #(_____)_____
ID/Policy # _____ Group#_____

RESPONSIBLE PARTY INFORMATION

(Complete this section if you are not the client but are responsible for the bill.)

Name_____ M____ F____
Birthdate _____/_____/_____
Relationship to Client _____ SSN# ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Address: _____ Phone # (__ __ __) __ __ __ - __ __ __ __
_____ Alt. Phone # (__ __ __) __ __ __ - __ __ __ __
Employer Name: _____ Occupation _____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature _____ Date _____

I authorize payment of medical benefits to the party who accepts assignment for services described below:
Signature _____ Date _____

Provider Signature _____ **Date** _____

For Office Use Only DX _____ _____ _____