Client Insurance Sheet

Client Information

Social Security Number **Name: Last** **First** **Middle**

Address: Street **City** **State** **Zip**

Phone Number **Alternative Number** **Sex** **Private E-mail Address**

Birth Date **Age** **Marital Status** **Length of Relationship** yrs mo.

Is it okay to leave a message?

How were you referred?

If you would like me to file with your insurance, **<u>You MUST complete the following, or you will be responsible for your visits</u>**. Be sure that a copy of your current insurance card has been attached to your file.

Insurance Information

Authorization Number **Number of Sessions**

Insurance Company of EAP Name

Insurance Phone Number **Insurance Billing Address**

ID Number (If Different from Social) **Group Number (If Applicable)**

Client Insurance Sheet

Primary Insurance Holder Information (please fill if different from client)

Social Security Number	Name: Last	First	Middle

Address: Street	City	State	Zip

Phone Number	Work Number	Cellular Number	Date of Birth

Payment Information

Is the client covered by a secondary health insurance policy?

Credit Card Number	Name on Credit Card	Exp Date	CCV/CCV2 Number

Billing Address (If Different): Street	City	State	Zip

Education:	Length of Employment:

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PATIENT SIGNATURE CONSERVATOR, OR PARENT **DATE**