Client's Name: __________________________________Client Social Sec # :___________________

DOB: __________________ Age:________ Sex: _________ Marital Status: ____________________

Client Address:____

City: _____________________________________ State: ____________ Zip: ___________________

Home Phone: ____________________________ Other Phone: _______________________________

Is it okay to leave messages? Y / N

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

Have you called your insurance company to verify benefits and request authorization? _____________

Authorization Number: ____ # Sessions: ___________

Insurance Company or EAP Name: ____

Insurance Phone # and Billing Address: ____

ID # if different from social: __________________________ Group Number if any:________________

Primary Insured Name __________________________________ Relation to client: ______________

Primary Soc. Sec:_____________________________ Primary Insured DOB: ____________________

Primary Insured's Employer: ____

Primary Insurance Holder if different from client:

Address: ____

City: _____________________________________ State: ____________ Zip: ______________

Home Phone: ____________________________ Other Phone: ______________________________

Is the client covered by a secondary health insurance policy? Y / N

If Yes, please request an additional form and fill out the same information for the secondary company.

Signature: _________________________________ Date: ______________________________