

INSURED/INSURANCE INFORMATION

Insured Name _____ Sex (circle) Female Male
Address _____ Soc. Sec. # _____
_____ Phone # _____
Relationship to client (circle): self spouse child other _____
Employer of Insured _____
Insurance Company _____ Insured Date of Birth _____
Address _____ Insured I.D. No. _____
_____ Group No. _____
Phone No. _____ Policy No. _____
Contact Person _____ Authorization No. _____

SECONDARY INSURANCE

Insured Name _____ Sex (Circle) Female Male
Address _____ Soc. Sec. # _____
_____ Phone # _____
Relationship to client (circle): self spouse child other _____
Employer of Insured _____
Insurance Company _____ Insured Date of Birth _____
Address _____ Insured I.D. No. _____
_____ Group No. _____
Phone No. _____ Policy No. _____
Contact Person _____ Authorization No. _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information. _____ Date _____

I authorize payment of medical benefits to the undersigned therapist for services described on claims. Signature _____ Date _____