INSURED/INSURANCE INFORMATION

Insured Name ___________________________ Sex (circle) Female Male

Address _____________________________ Soc. Sec. # ___________________________

_____________________________ Phone # _____________________________

Relationship to client (circle): self spouse child other _________________________

Insurance Company ______________________ Insured Date of Birth _________________

Address ______________________________ Member I.D. No. ____________________

____________________________ Group No. __________________________

Phone No. ____________________________ Auth No. ____________________________

SECONDARY INSURANCE

Insured Name ___________________________ Sex (Circle) Female Male

Address ______________________________ Member #: ___________________________

_______________________________ Phone #: _____________________________

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 ________________________

I understand that any unpaid balance will be sent to a collections agency, who reports the delinquent account to all three credit agencies:

Signature: ________________________________ Date _________________________

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