

Therapist _____

Client Information

Client Name: _____ Phone: ____/____-_____

Address: _____ Work Phone: ____/____-_____

City _____ State _____ Cell Phone: ____/____-_____

Zip _____ - _____ (9 digits: 5+4) Email address _____

SS# (Optional) _____ Birth Date: ____/____/____ Sex: M F

Primary

Secondary

Primary Insured: _____

Date of Birth: _____

Insured Date of Birth: _____

Rel. To Insured: Self Spouse Child Other

Self Spouse Child Other

Insurance Co: _____

Address: _____

Ins. Phone: ____/____-_____

____/____-_____

Policy/ID#: _____

Group#: _____

I hereby certify that the above statements are correct. I authorize the release of any medical information necessary to process this claim.

I also authorize benefits under this claim paid directly to the Physician or Supplier for services described.

Signed: _____

Date _____

Office Use Only

Diagnosis _____

Insurance Benefit information

Effective Date of Coverage _____

Copay/Coins _____

Deductible (Cal Yr/Contract Yr) _____

Authorization _____
(if needed)