INSURANCE INFORMATION & AUTHORIZATION FORM

Client Information

Client Name (Print)____ **Date of Birth** ____________________
Last Name First Name Initial

Street Address____ Home Phone ____________________

City________________________State__________ZIP______________ Cell Phone ____________________

Email ____ SSN: ____________________

Sex: Female Male Age __________ Partner Status: Single Married Widowed Divorced Separated Other

Insurance Company ____________________ Policy ID Number ____________________ Group Number ____________________

Policy Holder Information: (if the client is not the policy holder)

Name____Relationship ____________________
Last name First Name Initial

Address____________________City____________________State________Zip__________**Date of Birth**______________

Employer____

Employer Address ____Emplyer Phone:____________________

Circle Your Relation to Insured: Self Spouse Child Other

Responsible Party (Where should the client's portion of the bill be sent, if not to the client?)

Name ____ Relationship ____________________

Address____ Phone ____________________

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail client statements. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
Parent/Guardian Signature (if client is under 18 years old) Date