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:	_____	_____
Insured Date of Birth:	_____	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)