



Insurance Information Form

This form is sent to our biller. She needs to have info on you, the client, and the insured, if it is not you. Please bring this to your first (or next!) appointment.

Client Information

Name: _____ Phone _____

Address _____

City _____ State _____ ZIP _____

Date of birth _____

Insurance Information

Insurance company _____ Phone _____

ID/Policy # _____ Group # _____

Address _____

City _____ State _____ ZIP _____

Insured's name _____ Relationship _____

Date of birth _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____ Date _____