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INSURANCE INFORMATION

Client Name: ____
(First) (Last)

Client's Birth Date: ______/______/______ Gender of client: □ Male □ Female

Client's Address(stress/city/zip):____

Client's Phone: (______) ______________________ Work (______)_______________________

Client Status: □ Single □ Married □ Other □ Employed □ Full-time student □ Other (check all that apply)

("Policy Holder" refers to the name of the person who holds the insurance plan)

Client's relationship to the policy holder: □ Self □ Spouse □ Child □ Other:________________

Policy Holder Name: ____
(First) (Last)

Policy Holder's Address:____

Policy Holder's Phone: (______) ______________________ Work (______) ________________

Policy Holder's Birth Date: ______/______/______ Gender of Policy Holder: □ Male □ Female

Name of Insurance Company: ____

Policy Holder's ID #: __________________ Policy Holder's SS#: ________________________

Group #: _____________________________________

Name or Type of Plan: □ PPO □ Indemnity □ HMO □ EAP □ Other: ________________

Phone number for verification of benefits/eligibility (on back of card): (______) ____________

Address to send billing (on back of card): ____

Policy Holder's Employer: ____

What do you know about your deductible amounts? __________________________________

Do you know how much of your deductible you have met? □ No □ Yes, amount: _______

Does your insurance plan cover mental health treatment with a licensed clinical social worker? □ No □ Yes

What is your co-pay, or what percentage of the fee are you responsible for? ___________________________

How many sessions are allowed in your plan? _______How many sessions were approved? ______________

Name of Primary Care Physician: ________________________________ Phone #: (______) ______________