



Insurance Form

Client Information

Legal Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_
Address: \_\_\_\_\_
Street Address
City State Zip Code

Cell Phone: \_\_\_\_\_
Email Address: \_\_\_\_\_
Emergency Contact Information:
Name Relationship Phone Number

Primary Insurance Policy

Secondary Insurance Policy (if applicable)

Insurance Company: \_\_\_\_\_
Policy Holder's Name: \_\_\_\_\_
Relationship to Client: \_\_\_\_\_
Employer: \_\_\_\_\_
Subscriber/ Member ID #: \_\_\_\_\_
Group #: \_\_\_\_\_
Provider Phone: \_\_\_\_\_
Number (back of card)
Is this a Medicaid/Medicare Policy? [ ] Yes [ ] No

Insurance Company: \_\_\_\_\_
Policy Holder's Name: \_\_\_\_\_
Relationship to Client: \_\_\_\_\_
Employer: \_\_\_\_\_
Subscriber/ Member ID #: \_\_\_\_\_
Group #: \_\_\_\_\_
Provider Phone: \_\_\_\_\_
Number (back of card)
Is this a Medicaid/Medicare Policy? [ ] Yes [ ] No

\*Please send a copy of the insurance card (front and back) with the completed form

\*Please send a copy of the insurance card (front and back) with the completed form

Authorization to Release Information

I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor; 2) to verify insurance coverage; 3) to file a claim for insurance benefits related to professional services rendered.

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

OR

Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Email: \_\_\_\_\_

A member of our finance team will be contacting you to discuss the details of your or your loved one's benefits, cost of treatment, explain the process of obtaining authorization from the insurance company while you or your loved one is receiving treatment, and answer any questions you may have.

If you would like our finance team to contact someone else other than yourself, please provide their information below:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_