CLIENT INSURANCE

Name: _____ **DOB:** _____/____/_____ **Age:**_____
Month Day Year

Address:_____
Number and Street City State Zip

Phone: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
1st Choice 2nd Choice 3rd Choice

Social Security #: _____-_____-_____ **INSURANCE:** _____

Policy #: _____ **Group# :**_____

PHONE NUMBERS ON THE BACK OF THE INSURANCE CARD

(_____) _____ - _____ ..... _____
INSURANCE PHONE NUMBER DESIGNATED NAME

(_____) _____ - _____ ..... _____
INSURANCE PHONE NUMBER DESIGNATED NAME

CARD INFORMATION: _____
THE COMPANY OR EMPLOYER THE INSURANCE IS IN

_____ _____/_____/_____ _____-_____-_____
THE NAME THAT IS ON THE INSURANCE CARD THEIR DATE OF BIRTH THEIR SOCIAL SECURITY NUMBER

_____
THEIR ADDRESS CITY STATE ZIP

Please Be Advised

This information is necessary to assist you, and to confirm if I am a participating provider with your health insurance for verification and reimbursement purposes. Please call your insurance, and inform them of your wish to receive services by a Licensed Clinical Social Worker at Minges Brook Counseling. Verify my participation with your health insurance, and discover if there is any co-pays. Your signature below indicates that you understand the expectations upon you regarding this matter.

_____ _____
Client Signature Date