

**CLIENT INSURANCE INFORMATION**

Name : \_\_\_\_\_ DOB : \_\_\_/\_\_\_/\_\_\_\_ SS# : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address : \_\_\_\_\_  
Number and Street City State Zip Code

Phone Numbers : (\_\_\_\_) - \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_  
Home Phone Cell Phone 1<sup>st</sup> Choice to Call

Your Age : \_\_\_\_\_ Name of Your Health Insurance : \_\_\_\_\_

Your Policy or Identification # : \_\_\_\_\_ Group# : \_\_\_\_\_

The Company or Employer the Health Insurance is in : \_\_\_\_\_

The Person's Name That Is On The Insurance Card : \_\_\_\_\_

The Person's Birthdate : \_\_\_/\_\_\_/\_\_\_\_ SS# : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone # : (\_\_\_\_) - \_\_\_\_\_

**Phone Numbers On The Back Of The Insurance Card**

(\_\_\_\_) - \_\_\_\_\_ ..... \_\_\_\_\_  
Insurance Phone Number Designated Name Of This Phone Number

(\_\_\_\_) - \_\_\_\_\_ ..... \_\_\_\_\_  
Insurance Phone Number Designated Name Of This Phone Number

(\_\_\_\_) - \_\_\_\_\_ ..... \_\_\_\_\_  
Insurance Phone Number Designated Name Of This Phone Number

(\_\_\_\_) - \_\_\_\_\_ ..... \_\_\_\_\_  
Insurance Phone Number Designated Name Of This Phone Number

**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 this location. 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.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_