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CLIENT INSURANCE INFORMATION

If you plan to use insurance coverage for your care, please complete the requested information form below. Please remember that regardless of your insurance coverage, you are solely responsible for any charges incurred. Be prepared to provide a copy of your insurance card so that we can better follow-up on your coverage and benefits information.

Name of Insurance:_____

Telephone of Insurance:_____

Name of Insured (self, parent, spouse):_____

Insured's Social Security No.:_____Date of Birth_____

Group Number (if applicable):_____

Name of Primary Client (if different from insured):_____

Client's Social Security No.:_____Date of Birth_____

Insurance Claims Address:_____

Is pre-authorization or pre-certification required to use your insurance? Yes / No

Phone Number for pre-auth/pre-cert:_____

Pre-auth/pre-cert number:_____

Please discuss any relevant insurance information (i.e. you are anticipating a change in coverage, etc.):

_____