INSURANCE INFORMATION

PATIENT INFORMATION

Patient's name:_____ **Patient's Birth Date:**_____

Address:_____ **City:**_____ **State:**____ **Zip:**_____

Home phone: (_____)_____ **O.K. to leave msg? ☐ Cell: (_____)**_____ **O.K. to leave msg? ☐**

Sex: M ☐ F ☐____ **Patient's Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐**_____

Patient's Status: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐_____

Patient's Employer Name or School Name:_____

Patient's Insurance Plan Name:_____

PRIMARY INSURANCE

Insured's Name (inc. middle initial): _____ **Insured's I.D. Number:**_____

Insured's Address (if different from patient):_____ **City:**_____

State:_____ **Zip:**_____ **Home Phone:**_____ **Cell Phone:** _____

Insured's Policy Group Number:_____ **Insured's Date of Birth:**_____

Insured's Sex: M ☐ F ☐ _____ **Employer's Name (or School Name):**_____

Insurance Plan Name:_____

Secondary Insurance? Y ☐ N ☐___ **(if "Yes", please fill out information in "Secondary Insurance" section)**_____

SECONDARY INSURANCE

Insured's Name (incl. middle initial): _____ **Insured's I.D. Number:**_____

Insured's Address (if different from patient):_____ **City:**_____

State:_____ **Zip:**_____ **Home Phone:**_____ **Cell Phone:** _____

Insured's Policy Group Number:_____ **Insured's Date of Birth:**_____

Insured's Sex: M ☐ F ☐ _____ **Employer's Name (or School Name):**_____

Insurance Plan Name:_____

I authorize any insurance company to pay the proceeds of any benefits due me directly to the provider of record. I authorize the release of any medical, or other information necessary, to process an insurance claim. A copy of this agreement can be considered as an original for insurance purposes. If my insurance company requests information to be faxed, I understand that Perspectives Counseling, LLC has no control over the confidentiality of the information.

_____ _____

Signature of Patient or Legal Guardian Date