

**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