Perspectives Counseling LLC 2010 West 120th Avenue, Suite 204 Westminster, CO 80234 (303) 588-2087

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