

**REQUIRED INFORMATION: BRING THIS COMPLETED FORM TO YOUR FIRST SESSION**

You may need to call your insurance company or physician's office for some of the information

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient Status (Circle): MARRIED SINGLE OTHER • EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

Insurance I.D. #: \_\_\_\_\_ Phone: \_\_\_\_\_

Full Address: \_\_\_\_\_

**POLICY HOLDER NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Full Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**INSURANCE BENEFITS:** EAP AND SELF-PAY CLIENTS SKIP THIS SECTION

NAME OF INSURANCE COMPANY & CLAIMS ADDRESS: \_\_\_\_\_

\_\_\_\_\_

Claims Phone: \_\_\_\_\_ BENEFITS: Are the benefits "In-Network"? Y N

DEDUCTIBLE: Is there a Deductible? Y N What is the amount of the Deductible? \_\_\_\_\_

How much of the Deductible has been met? \_\_\_\_\_ COPAY: What is the amount of the Co-pay: \$ \_\_\_\_\_

AUTHORIZATION: Is Authorization (Pre-Certification) required? Y N

How many Sessions does your plan allow per Plan Year or per Calendar Year?: \_\_\_\_\_

Your Authorization Number?: \_\_\_\_\_ Number of Sessions Currently Authorized?: \_\_\_\_\_

What is the Beginning Date of this Authorization: \_\_\_\_\_ What is the End Date?: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** FULL NAME: \_\_\_\_\_

COMPLETE ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_