Insurance Information

Insured Client: _____

Primary Insurance:

Policy Holder: _____

Policy Holder Address, if different: _____

Employer of Policy Holder: _____

Insurance Co: _____Policy Number: _____

Insurance Company Address:_____

Insurance Company City: _____ State:_____ Zip:_____

Insurance Company Telephone: _____

Secondary Insurance:

Policy Holder: _____

Policy Holder Address, if different: _____

Employer of Policy Holder: _____

Insurance Co: _____Policy Number: _____

Insurance Company Address:_____

Insurance Company City: _____ State:_____ Zip:_____

Insurance Company Telephone: _____

I agree to allow the necessary sharing of information with the above insurance company(ies) about treatment dates, treatment planning, and diagnosis, to the extent necessary to insure reimbursement. This may also require periodic review of patient medical record.

Signature of Client/Client Guardian: _____

Witness: _____Date:_____