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HEALTH INSURANCE INFORMATION

If you are using, or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

CLIENT INFORMATION

Client's Full Name: _____

Street Address: _____

City:_____

State & Zipcode: _____

Client's Date of Birth:_____

Telephone: _____

Client's Sex: M_____ F_____

Client's Relationship to Insured: Self___ Spouse____ Child_____ Other_____

Client's status: Single____ Married___ Other_____ Stay-at-home Parent_____

Employed_____ Full-time Student_____ Part-Time Student_____

PRIMARY INSURANCE INFORMATION

(the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

Name of Insurance Carrier/Company: _____

Name of Policy Holder: _____

Street Address of Policy Holder: _____

City:_____

State & Zip code: _____

Policy Holder's Date of Birth: _____

Insurance Company's Phone Number: _____

Policy Holder's Employer: _____

Insurance Policy Plan Name: _____

Policy Holder's Member Number:_____

Policy Group Number: _____

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Carrier/Company: _____

Name of Policy Holder: _____

Street Address of Policy Holder: _____

City:_____

State & Zip code: _____

Policy Holder's Date of Birth: _____

Insurance Company's Phone Number: _____

Policy Holder's Employer: _____

Insurance Policy Plan Name: _____

Policy Holder's Member Number:_____

Policy Group Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Lindsey Burns, MS LPC LMHC NCC and authorize Lindsey Burns, MS LPC LMHC NCC to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

Insured Signature: _____

Date: _____