Intake Form and Insurance Information

Patient Name: _____

Gender: _____ Martial Status_____

Street Address: _____

City, State, Zip: _____

Patient date of birth: _____

Patient Insurance ID# (with letters) _____

Phone# of Provider Services & Mental Health (back of card)
_____

Name of Insured (subscriber) _____
(If other than the patient)

Insured's Street Address: _____

Insured's City, Sate, Zip: _____

Patient's relationship to insured: _____

Insured Date of Birth: _____ Gender: _____

I authorize the release of any information necessary to verify and process insurance claims. I fully understand that I am responsible for all charges not covered by my insurance carrier. I am aware that an agent of my insurance company, third-party payer, and insurance administrator may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I authorize payment directly to _____
I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: _____ Date: _____