Health Insurance Information

*Please provide us with insurance card so that we may make a copy

Insurance Company: ____________________________ ID# _________________ Group# __________
Name Insurance is in: ___________________________ SSN: _________________ Birth date ________
Employer: ____
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Secondary Insurance? Yes ( ) No ( )
Name Insurance is in: ___________________________ SSN: _________________ Birth date ________
Employer: ____
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

CONSENT TO OBTAIN AND RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN AND PSYCHIATRIST

I, the undersigned, authorize my therapist to communicate with the professionals below regarding all confidential professional medical information including personal, psychological, psychometric, medical records and opinions, and educational information:

Primary Care Physician Name: ____
Address: ____
____
Phone: (_____)____

Psychiatrist Name: ____
Address: ____
____
Phone: (_____)____

Patient/Guardian Signature: ____
Date: __________/__________/_______________