WILSON COUNSELING, LLC

HEALTH INSURANCE INFORMATION

DATE: ____________________ NEW or UPDATED THERAPIST: _____________________

CLIENT NAME: ____ GENDER: MALE/FEMALE

CLIENT DATE OF BIRTH: _________________________ CLIENT SSN: __________________________

IF OTHER THAN CLIENT, PERSON(S) RESPONSIBLE FOR ACCOUNT: _______________________________

____ I understand that each parent is equally responsible for payment of out-of-pocket expenses and that it is not the obligation of this agency to manage percentages.

CLIENT ADDRESS: ____
Street City State Zip

PHONE: ________________________________

EMAIL ADDRESS TO RECEIVE MONTHLY STATEMENTS: _______________________________________

___ I understand it is my obligation to ensure current health insurance information has been provided and I hereby accept responsibility for amounts not covered by insurance.

PRIMARY INSURANCE: _______________________________MEMBER ID: _______________________
POLICY HOLDER'S NAME IF DIFFERENT THAN CLIENT: ____
POLICY HOLDER'S EMPLOYER: ____
POLICY HOLDER DATE OF BIRTH: ____________________ POLICY HOLDER SSN: _________________

SECONDARY INSURANCE: ____________________________MEMBER ID: _______________________
POLICY HOLDER'S NAME IF DIFFERENT THAN CLIENT: ____
POLICY HOLDER'S EMPLOYER: ____
POLICY HOLDER DATE OF BIRTH: ____________________ POLICY HOLDER SSN: _________________
____

FOR STAFF USE ONLY:

DIAGNOSIS 1: ____

DIAGNOSIS 2: ____

DIAGNOSIS 3: ____

DIAGNOSIS 4: ____