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: _____

_____

CREDIT CARD AUTHORIZATION (optional)

I HEREBY GIVE CONSENT FOR THE FOLLOWING CREDIT/DEBIT CARD TO BE MAINTAINED ON FILE FOR CHARGES INCURRED AT WILSON COUNSELING.

Name as it appears on Credit Card: _____
Credit Card #: _____
Security Code: _____
Expiration Date: ____ / ____
Billing Zip Code: _____