Client Demographic and Billing Information

Name: _____ _____ _____
Last First Middle

Address: _____
_____

Home Phone : _____ Work phone: _____ Cell Phone: _____

Date of birth: _____ Email address:_____

Who may I thank for referring you? _____

(___) Primary insurance company: _____
Policy number: _____Policy holder's name: _____
Policy Holder's SS number: _____Policy Holder's date of birth: _____
Your relationship to insured?: _____Employer/Group: _____

PROVISIONS: Deductible amount $_____ Amount satisfied: $ _____
Insurance pays ____ % or $_____for visits Client pays $ _____
Type(s) of providers covered: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

Other third-party coverage: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Policy number: _____
Policy holder: _____
Other provisions: _____
_____

Completed procedures:___ Entered system Date: _____
___ Confirmed insurance Date: _____