



## INSURANCE INFORMATION DATA COLLECTION

### Client Information

Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Last First MI

SS# \_\_\_\_\_ Diagnoses \_\_\_\_\_ DOB \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Client Status:  Single  Married  Other \_\_\_\_\_  
 Employed  Full-time student  Part-time student

Party responsible for payment: \_\_\_\_\_  
Last First MI

Billing Address: \_\_\_\_\_

### INSURANCE/MEDICARE BENEFIT INFORMATION

#### Primary Insurance

Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Last First MI

SS# \_\_\_\_\_ Client's relationship to insured:  Self  Spouse  Dependent  Other

Insured's Status: DOB: \_\_\_\_\_  
 Single  Married  Other \_\_\_\_\_  
 Employed  Full-time student  Part-time student

Employer Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax : \_\_\_\_\_

Policy or Group #: \_\_\_\_\_ ID# : \_\_\_\_\_

Co-pay per visit: \_\_\_\_\_ Deductible: \_\_\_\_\_ % pd when met: \_\_\_\_\_

Out of pocket expense: \_\_\_\_\_ Amount remaining: \_\_\_\_\_

#### Secondary Insurance:

Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Last First MI

SS# \_\_\_\_\_ Client's relationship to insured:  Self  Spouse  Dependent  Other

Insured's Status: DOB: \_\_\_\_\_  
 Single  Married  Other \_\_\_\_\_  
 Employed  Full-time student  Part-time student

Employer Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy or Group #: \_\_\_\_\_ ID# : \_\_\_\_\_

Co-pay per visit: \_\_\_\_\_ Deductible: \_\_\_\_\_ % pd when met: \_\_\_\_\_

Out of pocket expense: \_\_\_\_\_ Amount remaining: \_\_\_\_\_