

## INSURANCE INFORMATION

If you would like to use insurance for our services, please complete this form.

Date: \_\_\_\_\_

**Insured's information:**

Insured's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box City State Zip

Phone#: Hm: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company phone #: \_\_\_\_\_

Insured's Member ID #: \_\_\_\_\_

Insured's DOB \_\_\_\_\_

**Patient's information (complete only if different from Insured's):**

Insured's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box City State Zip

Phone#: Hm: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company phone #: \_\_\_\_\_

Patient's Member ID #: \_\_\_\_\_

Patient's DOB \_\_\_\_\_

If your insurance company requires authorization, please call the member services number on your card for an authorization number. **If you are unsure, please call them in advance.**

If you do not know your co-pay, please call your insurance company in advance.

Auth # \_\_\_\_\_

Co-pay \_\_\_\_\_