

CONFIDENTIAL

Account Information

Insurance Information

Client's Name _____ Relationship to Policy Holder _____

Name of Policy Holder _____

Address _____

_____ Soc. Security # _____

Birthdate - Policy Holder _____

Employer: _____

Insurance Company _____

Billing address: _____

Ph. # Insurance Company: _____

Group Number: _____

ID Number _____

Insurance Release:

I understand that Jane Thompson, MSW, LICSW, BCD may be required to furnish information about me to the insurance company indicated above in order to receive payment for services provided and I authorize her to do so.

Signature: _____ Date: _____

Guarantee of Account:

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services provided. I certify that the above information is correct to the best of my knowledge and I will notify you of any changes.

Signature: _____ Date: _____