Primary Insurance

Name:____Date of Birth:_______________________________

Address:____

____

Home Phone #______________________________________Cell phone #_______________________________

Employer____

Employer's Address____

Employer Phone #____

Insurance Company__________________________________ Ins. Co. Phone: (_____)______________________

Client's Insurance ID#_________________________________ Group or Policy #__________________________

Client's Relationship to Insured (please circle one) Self / Spouse / Child / Other

Insured's Name: _____________________________________ Insured's DOB: ____________________________

Insured's Employer: ____

Insured's Employers Address____

Insured's ID#: _________________________ Group or Policy #: _________________________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.

Signature: ____ Date: ____________________________

I authorize payment of medical benefits to True Places Counseling, LLC for Mental Health Counseling Services. (Signature of file).

Signature: ____ Date: ____________________________