

Insurance & Client Information

Client Name: _____ Date of Birth: _____

Address: _____

City, State, ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Social Security Number: _____

I give consent for Alliance to contact the subscriber(s) regarding any insurance issues.

Primary Insurance

Insurance Company: _____

Identification Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Full Address: _____

Subscriber Phone Number: _____

Relationship to Client: Self Spouse Child Other: _____

Secondary Insurance

**I understand it is my responsibility to ensure a Coordination of Benefits has been completed with each of my Insurances. Initials _____*

Insurance Company: _____

Identification Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Full Address: _____

Subscriber Phone Number: _____

Relationship to Client: Self Spouse Child Other: _____

Bill Payment Policy: Therapists at Alliance Counseling & Coaching are independent professionals and are paid only when insurance, copays & coinsurance are received. I will inform the office of any changes to my insurance. I confirm that all of the information provided is accurate.

Signature: _____ Date: _____