Insurance Information

Client's name _____

Primary Insurance

Insurance Company _____

ID #_____ Group ID# _____

Policyholder [if not client] _____ DOB _____

Home Address _____ Gender _____

Phone # _____ Employer _____

Relationship to Policyholder: Self Spouse Child Other _____

Ins. Mental Health Benefits Phone # _____

Secondary Insurance

Insurance Company _____

ID #_____ Group ID# _____

Policyholder [if not client] _____ DOB _____

Home Address _____ Gender _____

Phone # _____ Employer _____

Relationship to Policyholder: Self Spouse Child Other _____

Ins. Mental Health Benefits Phone # _____

If Applicable, Employee Assistance Program (EAP) Insurance

Company _____ Phone _____

Effective Date: _____Authorization # _____ # of sessions _____

Refresh Therapy, Inc has my permission to communicate with my insurance company and to provide information necessary for the purpose of authorizing services, billing, and provision of services and/or coordination of care. I understand that I will be required to pay for missed appointments or late cancellations (insurance does not cover), as well as any charges that my insurance does not cover.

_____

Client/Parent/Guardian Signature Print Name Date