NEW CLIENT BILLING INFORMATION

CLIENT INFORMATION		
THERAPIST NAME:		
CLIENT NAME:		
Date of birth:	1ST Date of Service:	Phone:
Current address:		
City:	State:	ZIP Code:
M or F *(for insurance purposes only)*	Email:	
*If Applicable Name of Parent/Guardian or Primary Insurance Subscriber:		
Home Address:		
City:	State:	ZIP Code:
Work Phone:	Cell Phone:	Email:
Paying out of pocket	Agreed Upon Rate $	Please DO NOT complete the Insurance section if paying out of pocket

INSURANCE INFORMATION		
Primary Insurance:		
Phone Number from Insurance Card:		Group #:
Contract or ID#:		Subscriber DOB:
*Subscriber Name:		
Relationship to Client:		
Secondary Insurance (if any):		
Subscriber Name:		Subscriber DOB:
Relationship to Client:		
Contract or ID#:		Group #:

OFFICE USE ONLY **Benefit Inquiry**		
Date:	Spoke to:	
Coverage Through:		Effective:
Copay:	Deductible:	Max/year:
Authorization: Yes?	No?	
Limitations:		
Auth#:	No of visits:	DX:
Date Range:		

Comments: