HEALTH INSURANCE INFORMATION

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company and must be completed before your first session.

PATIENT INFORMATION:

1. PATIENT'S FULL NAME _____
2. STREET ADDRESS _____
3. CITY, STATE & ZIP CODE _____
4. PATIENT'S DATE OF BIRTH _____
5. TELEPHONE _____
6. PATIENT'S SEX M_____ F_____
7. PATIENTS' RELATIONSHIP TO INSURED:
   SELF___ SPOUSE____ CHILD_____ OTHER_____
8. PATIENTS' STATUS:
   SINGLE____ MARRIED___ OTHER_____
   EMPLOYED_____ FULL-TIME_____STUDENT____ PART-TIME_____
9. SOCIAL SECURITY # _____

INSURED'S INFORMATION (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

1. NAME OF INSURED:_____
2. STREET ADDRESS OF
   INSURED:_____
3. CITY, STATE & ZIP CODE:_____
4. INSURED'S DATE OF BIRTH:_____
5. SOCIAL SECURITY #: _____
6. TELEPHONE: _____
7. INSURED'S PLACE OF EMPLOYMENT: _____

8. INSURANCE PLAN NAME OR PROGRAM NAME:

_____

9. INSURED'S INSURANCE ID NUMBER:_____

10. POLICY GROUP NUMBER:_____

***Financial Agreement and Authorization assignment of insurance benefits: payment is requested at the time services are rendered unless other financial arrangements are made. I understand that I am responsible for any health insurance deductibles or copayments. I give full consent for completion of an evaluation and the provisions of ongoing mental health treatment as necessary until I otherwise notify this clinician. I agree that the information above is accurate and complete to the best of my knowledge.**

I give my consent and authorization to Stacie Crochet, LCSW to bill my insurance noted above and I further acknowledge that my co-pay is _____to be paid at the time of the session or at the time otherwise arranged.

Signed:_____ Date:_____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Stacie Crochet, LCSW, and authorize Stacie Crochet, LCSW to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

Signed:_____ Date:_____