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.

PATIENT INFORMATION:

1. PATIENT'S FULL NAME _____
2. STREET ADDRESS _____
3. CITY _____
4. STATE & ZIP CODE _____
5. PATIENT'S DATE OF BIRTH _____
6. TELEPHONE _____
7. PATIENT'S SEX M_____ F_____
8. PATIENTS' RELATIONSHIP TO INSURED: SELF___ SPOUSE____ CHILD_____ OTHER_____
9. PATIENTS' STATUS:

   SINGLE____ MARRIED___ OTHER_____

   EMPLOYED_____ FULL-TIME STUDENT_____ PART-TIME STUDENT_____

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 INSURANCE CARRIER** _____
2. NAME OF INSURED _____
3. STREET ADDRESS OF INSURED _____
4. CITY _____
5. STATE & ZIP CODE _____
6. INSURED'S DATE OF BIRTH _____
7. INSURANCE COMPANY TELEPHONE _____
8. INSURED'S PLACE OF EMPLOYMENT: _____
9.. INSURANCE PLAN NAME OR PROGRAM NAME. _____
10. INSURED'S INSURANCE ID NUMBER_____
11. POLICY GROUP NUMBER _____

SECONDARY INSURANCE

1. **INSURANCE CARRIER** _____
2. NAME OF INSURED _____
3. STREET ADDRESS OF INSURED _____
4. CITY _____
5. STATE & ZIP CODE _____
6. INSURED'S DATE OF BIRTH _____
7. INSURANCE COMPANY TELEPHONE _____
8. INSURED'S PLACE OF EMPLOYMENT: _____
9. INSURANCE PLAN NAME OR PROGRAM NAME. _____
10. INSURED'S INSURANCE ID NUMBER_____
10. POLICY GROUP NUMBER _____

REFERRING PHYSICIANS NAME _____

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 Gretchen Burkholder, LMHC and authorize Gretchen Burkholder, LMHC to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

SIGNATURE OF INSURED _____ Date _____