HEALTH INSURANCE INFORMATION

CLIENT INFORMATION:

1. PATIENT'S FULL NAME:
2. PATIENT'S DATE OF BIRTH:
3. STREET ADDRESS:
4. CITY:
5. STATE & ZIP CODE:
6. TELEPHONE:

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. INSURED'S DATE OF BIRTH:
4. STREET ADDRESS OF INSURED (if different than client):
5. INSURANCE COMPANY TELEPHONE:
6. INSURED'S PLACE OF EMPLOYMENT:
7. INSURANCE PLAN NAME OR PROGRAM NAME:
8. INSURED'S INSURANCE ID NUMBER:

SECONDARY INSURANCE

1. **INSURANCE CARRIER**
2. NAME OF INSURED:
3. STREET ADDRESS OF INSURED (if different than client):
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:

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