Insurance and Billing Information

Name of Insured: ___________________________ Relation to Patient: _______________

DOB: ___________________Social Security Number: ______________________________

Address (if different from that of patient): ____

Insurance: ____

Member ID#: _____________________________Group #: __________________________

Insurance Provider Phone: (___)______-_______________________________________

Insurance Address: ____

By signing below I am confirming that all of the above information is accurate. I also recognize that I am responsible for any insurance co-payments due at the time of service.

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Client Signature

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Parent/Legal Guardian