CENTERED

700 Alhambra Blvd, Lower▪ Sacramento, CA 95816 (916) 835-9034

Client Insurance Form

NAME: _____
Last, First, MI

ADDRESS: _____

CITY _____ ZIP_____

SSN: _____

INSURED ID NUMBER: _____

Phone Number: _____

Date of Birth: _____ Sex: Male or Female

Name of Insurance: _____

Name of Insured (if other than yourself) :_____

Date of Birth of Insured: _____ Relation to Insured: _____

Social Security Number of Insured: _____

Insurance Policy Number of FECA number: _____

*Phone Number of Insurance: _____

Clients who carry insurance should remember that the client, not the insurance company, is responsible for payment. I will bill your insurance company for you if I am a provider for that company. You will be required to pay your co-pay at each session. If your insurance company denies payment or makes partial payment, the balance will be due upon notification and/or charged to your credit card within 24 hours unless other arrangements are made.

____Credit Card on file.

____Copy of Insurance card on file

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to either myself or to the party who accepts assignment below.

_____ _____

SIGNED DATE