INSURANCE INFORMATION SHEET

It is important that you thoroughly complete this form and provide a copy of both sides of your insurance card(s). Thank you.

Therapist's Name: ___________________

CLIENT INFORMATION

Name:		Birth Date:
Address:		SS#:
City:	State:	Zip:
Home Phone:		Mobile Phone:
Employer:		
Is client a dependent child? Yes or No	Martial Status: (Circle one) M S Other	

PRIMARY INSURANCE INFORMATION

Who is the Insured:	SS#:	Birth Date:
Employer of Insured:	Work Phone:	
Insurance Co.: Policy #:	Group #:	
Customer Service Phone:	Mental Health Phone:	

DO YOU HAVE SECONDARY INSURANCE? Yes or No

Who is the Insured:	SS#:	Birth Date:
Employer of Insured:	Work Phone:	
Insurance Co.:	Policy #:	Group #:
Customer Service Phone:	Mental Health Phone:	

DO YOU HAVE EAP? Yes or No

Name of EAP:	Phone # of EAP:	
Authorization #:	Sessions Authorized: From	To

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that Conant Associates LLC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold Conant Associates LLC liable for insurance nonpayment due to misquoted benefits. I acknowledge I am responsible to know and understand my benefits plan. Conant Associates LLC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request assigned benefits be paid to Conant Associates LLC and/or the provider indicated above.

Signature of Client and/or Insured:____________________
Date: ______________