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# Information and Authorization Form

Patient Name _____ Date of Birth _____
Social Security Number _____ Sex: Male or Female
Address _____ City _____ Zip _____
Contact Phone #1 _____ Contact Phone #2 _____
Email Address _____

Responsible Party Name _____
Address _____ City _____ Zip _____
Contact Phone #1 _____ Contact Phone #2 _____

**Primary Insurance**
Insured's Name _____ Insured's Date of Birth_____
Social Security Number of Insured _____
Insured's Employer _____ Relationship to Patient _____
Insurance Company Name _____
Insurance Company's Phone Number _____
ID Number _____ Group Number _____

**Secondary Insurance**
Insured's Name _____ Insured's Date of Birth_____
Social Security Number of Insured _____
Insured's Employer _____ Relationship to Patient _____
Insurance Company Name _____
Insurance Company's Phone Number _____
ID Number _____ Group Number _____

Type of Credit Card: Visa or MasterCard Expiration Date on Card: _____
Name on Card: _____
Credit Card Number: _____ CVC# _____

**Option to NOT use your insurance** (If you ARE using your insurance, please disregard this section)
*** My signature acknowledges that I am choosing to NOT use my insurance. I understand that by choosing this option, it may cause me to forfeit a reduced provider rate, and I agree to pay the full fee for services. I will not attempt to file these claims in the future. If I choose to use my insurance in the future, I will inform my counselor in advance, and will sign another authorization form and include my insurance information.***
Signature: _____ Date: _____

I hereby authorize payment of fees, covered by the insurance company, to be paid directly to the provider. This signature applies to all dates of service for the duration of treatment. I understand this also authorizes the provider to give out information to the insurance company in order to obtain payment. If the insurance company does not pay within 60 days, I am ultimately responsible for the entire amount due. My signature also authorizes the use of my credit card as payment for services, as outlined in the Client Services Agreement.

_____ _____
**Signature** **Date**

Dx Code (for provider to fill out) 1._____ 2._____ 3._____ 4._____ 5._____