

THREE PEAKS COUNSELING

CLIENT INFORMATION AND INSURANCE REGISTRATION

Client's First Name: _____ M.I.: _____ Last Name: _____

Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: Home: _____ Okay to leave message? (Circle one) Yes No

Tel: Work: _____ Ext _____ Okay to leave message? (Circle one) Yes No

Tel.: Cell _____ Okay to leave message? (Circle one) Yes No

Which number do you prefer us to call and leave message? (Circle one) Home Work Cell

Employer: _____ Address: _____

INSURANCE INFORMATION (Complete the following if using insurance benefits)

Primary Policy Holder's Information (person who is primary on the policy, often different from the client)

First Name: _____ M.I.: _____ Last Name: _____

***Primary Policyholder's Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Relationship to Patient: _____

Employer: _____ Address: _____

PRIMARY INSURANCE:

Insurance Company: _____ Address: _____

Insured's ID#: _____ Group/Plan #: _____

Phone #: _____

SECONDARY INSURANCE:

Insurance Company: _____ Address: _____

Insured's ID#: _____ Group/Plan #: _____ Group Name: _____

Phone: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself, my provider, or Three Peaks Counseling.

Client Signature: _____ Date: _____

I authorize payment of medical benefits to my provider or Three Peaks Counseling for services.

Client Signature: _____ Date: _____

For office use only

Date: _____

Insurance Rep _____

Effective Date _____ Deductible _____ Fam Ded _____

Deductible Remaining _____

In Network _____ Patient Co-Pat/Co-Ins _____

Maximum Visits or Amount Paid _____

Authorization Required? _____ Authorization # _____

Out of pocket maximum: _____