Therapist_____
DSM IV_____
Auth #_____
Date_____

INSURANCE INFORMATION PAGE

PRIMARY CLIENT INFORMATION:

Client: _____, _____, _____
Last First M.I.

Address: Street_____ City_____ State_____ Zip_____
Date of Birth _____ Sex _____ S.S. # _____
Home Phone _____ Work Phone _____

PRIMARY INSURED:

Insured Name _____ Date of Birth _____ Sex_____
SS#_____ Relationship to Client_____
Address: Street _____ City _____ State_____ Zip _____
Home Phone _____ Work Phone _____
Occupation _____ Employer_____

Insurance Co. Name _____ Phone _____
ID# _____ Group #_____

SECONDARY INSURED: (If applicable)

Insured Name _____ Date of Birth _____ Sex_____
SS#_____ Relationship to Client_____
Address: Street _____ City _____ State_____ Zip _____
Home Phone _____ Work Phone _____
Occupation _____ Employer_____

Insurance Co. Name _____ Phone _____
ID# _____ Group #_____

I authorize my insurance company to make payment directly to Cornerstone Counseling Center at 4037 Parchman St. Fort Worth, Tx. 76180 for services rendered.

Signature:X_____ Date:X_____