

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: _____ Date: _____