Willows Edge Client Insurance Information **Provider: _____**

Client's Name (Last)_____(First)_____(MI)_____

Client's relationship to insured: self_____spouse_____child_____

Address_____City_____State_____ZIP_____

Phone_____DOB_____M_____F_____

Single____ Married____ Widowed____ Employed____ Retired____ Unemployed____ FT Student____

Primary Insurance

Primary Insurance (Include type: PPO, HMO, Medicaid, Etc) _____

Person Covered_____ Member Sex: M_____F_____

Claims Address_____City_____State_____ ZIP_____

Claims Phone Number_____

Primary Insured's DOB_____ Policy #_____Group #_____

SS# (if required by your insurance company)_____

Secondary Insurance

Secondary Insurance (Include type: PPO, HMO, Medicaid, Etc) _____

Person Covered_____ Member Sex: M_____F_____

Claims Address_____City_____State_____ ZIP_____

Claims Phone Number_____

Primary Insured's DOB_____ Policy #_____Group #_____

SS# (if required by your insurance company)_____

By signing this form I give Willows Edge permission to release my client records to my insurance company for payment of all services rendered. I also understand that co-payments are paid at the time of service. A no show fee will be charged for appointments not cancelled 24 hours in advance.

Client signature or Parent/Legal Guardian_____

Relationship to minor_____

Witness signature _____

Date/Date of Intake: _____ DX _____