HARBORSIDE COUNSELING

Insurance Data Form

Name:_____

Address:_____

_____

Date of Birth_____ Age_____ SS #: _____-_____-_____

Are you a Student? Yes / No Marital Status:_____

Primary Care Physician: _____

Do I have your permission to inform your PCP that you are in treatment with me? Yes / No

If so, please provide the following:

PCP Address_____ Phone number_____

IF YOU CHOOSE TO PAY FOR SERVICES BY ACCESSING YOUR MENTAL HEALTH BENEFITS UNDER YOUR MEDICAL INSURANCE, COMPLETE THE FOLLOWING:

Primary Insurance

Primary Insurance Carrier: _____ ID# _____

Policy Holder: _____ Relationship to Client: _____

DOB of Policy Holder: _____ SS# of Policy Holder: _____-_____-_____

Employer Providing Insurance Coverage: _____

Telephone Number for mental health benefits (from back of card) _____

Secondary Insurance

Secondary Insurance Carrier: _____ ID# _____

Policy Holder: _____ Relationship to Client: _____

DOB of Policy Holder: _____ SS# of Policy Holder: _____-_____-_____

Employer Providing Insurance Coverage: _____

Telephone Number for mental health benefits (from back of card) _____

Your signature below allows this office to provide clinical information, which includes such information as dates and types of services provided, diagnosis, progress towards treatment goals, and so forth, to your health insurance carrier(s) for the purposes of obtaining payment for services rendered:

Signature:_____ Date:_____