



PRESCREEN INSURANCE INFORMATION

Please provide a copy of the front and back of your insurance card if emailing this to your therapist. If you are bringing this form with you, please have your card available.

- 1. **Client's name:** _____
- 2. **Date of Birth:** _____
- 3. **Contact phone number:** _____
- 4. **Home address:** _____
- 5. **Date authorization initiated:** _____
- 6. **Name of Insurance Company:** _____
- 7. **Insurance ID# of client:** _____
- 8. **Phone number to call for mental health or provider services** (located on back of insurance card): _____
- 9. **Relationship to insurance subscriber** (if not client): _____
- 10. **Subscriber information** (if not client):
 - Name:** _____
 - DOB:** _____ **Gender:** _____
 - Address:** _____
 - _____
- 11. **Name and phone number of the person who referred you:** _____
- _____
- 12. **Emergency contact person (name and phone numbers):** _____
- _____
- 13. **Person financially responsible for making any insurance co-payments/deductibles:**
- _____
- 14. **Copay:** _____