

Carol Breeding Arvin, M.A.

Intake/Insurance Information

Client information

Today's date: _____

Name: (first, middle initial, last) _____

Address: _____ City/state/zip _____

Phones: Cell _____ Other(type): _____

Date of birth: _____ email: _____

Insured party (if different than client)

Name: (first, middle initial, last) _____

Address: _____ City/state/zip _____

Phones: Cell _____ Other(type): _____

Date of birth: _____ email: _____

Insurance information:

Insurance company/plan name: _____

Member ID# _____ Group #: _____

Employer: _____ Referred by? _____

Customer service phone number: _____ Payer ID: _____

Claims mailing address: _____

I hereby authorize release of information required to process claims and authorize payment to my counselor. I also agree to pay any fees still owing after insurance claims have been processed and remitted.

If I am not using insurance, I agree to pay all fees agreed upon with my counselor.

Client or insured party signature: _____ Date: _____

Office use only:

Dx _____ # sessions _____ Deductible _____ Copay _____

(last updated 10/1/18)