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)