# Carol Breeding Arvin, M.A.

## Intake/Insurance Information

**Client information** Today's date:_____

Name: (first, middle initial, last)_____

Address:_____City/state/zip_____

Phones: Cell _____Home_____ Work _____

Date of birth:_____ email:_____

**Insured party (if different than client)**

Name: (first, middle initial, last)_____

Address:_____City/state/zip_____

Phones: Cell _____Home_____ Work _____

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_____