BLACK THERAPIST & COMPANY, LLC

IINSURANCE VERIFICATION DEMOGRAPHICS INFORMATION

(To be completed by client)

TODAY'S DATE_____

IDENTIFYING INFORMATION

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____Relationship Status:_____

Partner's Name (if being seen as a couple): _____

Address: _____City, State, Zip: _____

Home phone: _____ Work phone:_____

Partner's phone: _____

Social Security (ID) Number: Self: _____N/A_____

May we leave messages for you at home? ☐ Yes ☐ No

May we leave messages for you at work? ☐ Yes ☐ No

Gender as Specified on Insurance: ☐ Male ☐ Female

Gender Self-Identification, if different: ☐ Male ☐ Female ☐ OTHER _____

Others Living in Home (name, birth date, relationship to client): _____

_____

Education: Self: _____Partner: _____

Occupation: Self: _____Partner: _____

Client's Employer: _____

Emergency Contact: _____Phone: _____

Referred by: _____

INSURANCE INFORMATION (leave blank for self pay)

Name of Insured: _____Insured Date of Birth:_____

Address of Insured:_____

City, State, Zip: _____

Relationship of Client to Insured: _____

Employer of Insured:_____

Insurance Company:_____Phone: _____

Insurance Company Address: _____

City, State, Zip:_____

Insurance Identification Number: _____

Group Number: _____

Secondary insurance: _____ Phone: _____

Name of Secondary Insured: _____ Insured Date of Birth: _____

Secondary Company Address: _____

City, State, Zip: _____

Secondary Identification Number: _____

Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____

Signature Date

FOR PROVIDER USE ONLY	
DSM-5: DIAGNOSIS:	ICD-10 DIAGNOSIS: