Catalyst Counseling
Associates

CHANGE / UPDATE OF INFORMATION

Date: _____ **Name of person providing information**: _____

Client Name: _____ Date of Birth: _____

Provider: _____ Account #: _____

Home Phone: _____ Message Okay? YES NO

Work Phone: _____ Message Okay? YES NO

Cell Phone: _____ Message Okay? YES NO

Address: _____

_____

*Insurance Name: _____ *ID Number: _____

*Group Number: _____ *Phone Number: _____

*Subscriber: _____ *Employer: _____

Address: _____

Effective Date of Insurance: _____ **Circle one: Primary Secondary**

Is there another active insurance policy? YES NO

Reason for Change: ☐ Additional Policy ☐ All EAP used

☐ Old Policy no longer active

☐ Other _____

Please note: If you have a new insurance company, please present your new insurance card at time of appointment. Thank you.

For Office Use:

_____ Client phoned in _____ Appt. Set: _____ Copy of Insurance Card