Client Information Sheet

Date: _____

Full Name (Formal Name):_____ Marital Status: Married Single Other

Date of Birth: _____ SS#:_____

Address: _____ City, State, Zip Code _____

Email Address_____

Phone Number: Home (_____) _____ Cell (_____)_____Work (_____)_____

Primary Care Physician: _____

Employment: _____

Who referred you to this office: _____

Insurance Information

Primary Insured Name (Formal Name) _____ _____Date of Birth_____

Address if different then above_____

Email Address of Primary Insured_____ ___

SS# of Primary insured _____ _____ Marital Status of Primary Insured: Married Single Other

Insurance Company Name_____ Member ID #_____

Group #_____ Customer Service Phone Number(Back of Card) _____

Name of employer: _____ Who is financially responsible for this bill?_____

Please provide a copy of the front and the back of the insurance card to your provider.

Release of Information for Insurance Verification/Authorization of Benefits /Claims Processing/Fee/Payment

Please initial below

____I authorize Lisa Wilson and its subsidiaries, to check/verify insurance coverage and benefits.
____I authorize the release of any medical or other information necessary to process claims related to services provided by Lisa Wilson.
___I authorize payment of medical benefits to Lisa Wilson for services provided.
___I understand and agree that I am financially responsible to pay for co-pay/coinsurance/deductible/other services not covered by my insurance.

Client Signature or Authorized Person's Signature_____ Date _____

For Therapist only:

Preauthorization Number: _____

Primary Diagnosis: _____