# KIM HUMPHRIES & ASSOCIATES

## ANNUAL CLIENT UPDATE/VERIFICATION FORM

Name _____ Date____/____/_____

Street Address _____ DOB____/____/_____

City, State, Zip _____ Age_____

Contact information: Home ( )_____-_____ Work ( )_____-_____

Cell ( )_____-_____ **Please note which is best contact number: Home __ Work __ Cell __*

**Please indicate if we may leave a message. Yes ____ No ____*

Email _____

** Please note email & texts are not encrypted. Therefore, we cannot guarantee confidentiality for these forms of communication.*

Occupation _____ Employer_____

Marital Status: S____ M____ D____ W____

_____ ( )_____

Client's emergency contact Contact's phone number

**INSURANCE INFORMATION**

Name of Insured _____ DOB of Insured ____/____/_____

Client Relationship to Insured_____

Place of Employment _____

Name of Insurance Company _____

Insurance Address _____

City_____ State_____ Zip_____Phone ( )_____-_____

Policy/ID Number #_____ Group # _____

**Authorization to Release Information** _____ ____/____/_____

(Without the above signature, insurance cannot be filed) (Signature) (Date)

Authorization to Pay Medical Benefits to Clinician _____ ____/____/_____

(Signature) (Date)