

### CLIENT INTAKE & INSURANCE INFORMATION

Please complete all applicable sections. Accurate and complete information is required to verify insurance and process claims.

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Client Full Legal Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Responsible Party (if different from client): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### PRIMARY INSURANCE

Primary Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Member ID/ Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

#### SECONDARY INSURANCE

No Secondary Insurance

Secondary Insurance: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Member ID/ Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

#### AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that the information provided is true and complete. I authorize Daring Minds Therapy, LLC to verify insurance benefits, obtain prior authorization when required, coordinate care, and submit claims for payment. I authorize payment of benefits directly to Daring Minds Therapy, LLC. I understand that I am financially responsible for all copayments, deductibles, coinsurance, and other amounts I am legally required to pay. I agree to notify the practice of any changes to my insurance or contact information. I consent to being contacted by phone, voicemail, text message, or email for scheduling, billing, and other administrative purposes. Standard messaging and data rates may apply.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_