CHRISTIAN COUNSELING CENTERS OF OREGON & WASHINGTON

Amanda M. Allen M.A., LPC
P.O. Box 1991, Tualatin, Oregon 97062
Phone: 503-636-4176

INSURANCE INFORMATION:
Services can not be rendered with out the bold information being filled out correctly.

Client's Name:_____ **Today's Date:**_____
Age:_____ **Birth date:**_____ Marital Status:_____ Gender:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Work Phone:_____
Cell Phone: _____ Email: _____
May we leave a message for you at home?_____ at work?_____ on cell? _____
Preferred method of communication: _____

Spouses' Name:_____ (if applicable)
Age: _____ **Birth date:**_____ Gender:_____

In the case that client is a minor; please state parent's name(s):
Mother:_____ Father:_____
Legal Guardian: _____
Living Situation:_____

Name of Insured Subscriber: _____
Relationship to client above: _____
Employer: _____
Insurance Company: _____ **Phone #:**_____
Billing address: _____
City/St/Zip_____
Insurance ID Number:_____ **Group Number:**_____
Deductible: _____ **Co. Pay** _____

Patient of Authorized Person's Signature: I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to the provider of services. I agree to pay any balance not covered by the insurance company.

Signature **Date**