SpeakLife

Counseling & Professional Development Services

Dominique Dillard, LPC, M.S.

Insurance Information

Client Name: ______________________________________Birthdate: ____/____/____Sex: [ ] Male [ ] Female

Mailing Address: _____________________________________ May we use for mailing purposes? [ ] Yes [ ] No

City: ______________________________ State: __________ Zip ___________ SS#______________________(18yrs-Up)

Home Phone #: ___________________ Work ___________________Cell Phone: ________________________

Okay to call and or leave messages at [ ] Home [ ] Work [ ] Cell Marital Status: [ ] S [ ] M [ ] D [ ] W

E-mail:_____________________________________ Spouse: ____

Referred By: _______________________________Primary Care Doctor _________________ Phone: __________

Nearest relative not living in same household: Name __________________________Phone #:_________________

PARENT OR GUARDIAN INFORMATION (Responsible Party)

Parent/Guardian/Guarantor: ________________________________ Birthdate: _____________ Sex: [ ] M [ ] F

Address: _______________________City: ________________State: _____ Zip: _______Phone#: ____________

SSN#: __________________ Work Phone #:_______________________ Occupation: ________________________

Employer: ________________________________ Address: ____

City: _______________________________________ State: _________________________ Zip: ______________

Relationship to Client: ____________________________ E-mail _____________________________________

INSURANCE INFORMATION (Policy Holder's SS# is Required)

Policy Holder's Name: ___________________________________ Birthdate: __/___/___ Sex: [ ] Male [ ] Female

Address: _______________________City: ________________State: _____ Zip: _______Phone#: ____________

Employer: ____ Insurance Carrier: ___________________________

Policy #: _____________________________ Group #: ________________________ Effective Date: ___________

SS# of Insured: ________________________ Relationship to Client: ___________________________________

Filing your insurance is a courtesy we provide for you. Since your insurance policy is a contract between you and your insurance company, the Guarantor/client/guardian is still responsible for co-pays or unpaid balances. Collection fees, due to any unpaid balance, is the responsibility of the Guarantor/client/guardian.

Insurance Authorization/Release of Information: I authorize any holder of records at SpeakLife Counseling or other information about me to release said information to health care financing administration and its agents any information needed to determine these benefits for related services. I authorize payment to be paid directly to **Dominique Dillard.** This is a lifetime authorized signature which may be revoked in writing at any time.

Guarantor/Client/Guardian:____ Date: __________________