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Client Insurance Information

Client's Name _____

Client's Date of Birth _____

Insured's Name _____

Primary Insurance
Company Name _____

Insurance Claims _____

Mailing Address _____

City: _____ State: _____ Zip: _____

Group Number _____

Policy ID Number _____

Effective Date of Coverage _____

I understand that claims are filed as a courtesy extended to me and that I am financially responsible for all charges whether or not my insurance pays for these services. I authorize the release of any information necessary to process claims and secure payment from my insurance company. Please include a copy of your insurance card with this form.

Signed _____

Date _____

Cell Phone _____

Email Address _____