# Carol Breeding Arvin, M.A.

## Intake/Insurance Information

**Client information** Today's date:________________

Name: (first, middle initial, last)__________________________________________

Address:________________________City/state/zip__________________________

Phones: Cell ________________Home______________ Work ________________

Date of birth:________________________ SS#______________________________

**Insured party (if different than client)**

Name: (first, middle initial, last)__________________________________________

Address:________________________City/state/zip__________________________

Phones: Cell ________________Home______________ Work ________________

Date of birth:________________________ SS#______________________________

**Insurance information:**

Insurance company/plan name:___________________________________

Member ID#_____________________________ Group #:_____________

Employer:________________________ Referred by?__________________

Customer service phone number:___________________________ Payer ID:_______

Claims mailing address:____________________________________________

_______________________________________________________________

I hereby authorize release of information required to process claims and authorize payment to my counselor. I also agree to pay any fees still owing after insurance claims have been processed and remitted.
If I am not using insurance, I agree to pay all fees agreed upon with my counselor.

Client or insured party signature:___________________________Date:________

Office use only:
Dx__________ # sessions_________ Deductible___________ Copay________

## Carol Breeding Arvin, M.A.

## Intake/Insurance Information

**Secondary Insurance information:** ____

Today's date________________

Client name:________________________________________

**Insured party:**

Name: (first, middle initial, last)_________________________________

Address:________________________________________________

City/state/zip__________________________ Home phone:_____________

Cell phone:___________________ Work phone:______________

Date of birth:_____________________ SS#______________________

Insurance company/plan name:____________________________

Member ID#__________________________ Group #:____________

Employer:___________________________

Customer service phone number:________________________ Payer ID:_______

Claims mailing address:_______________________________________

________________________________________________________

I hereby authorize release of information required to process claims and authorize payment to my counselor. I also agree to pay any fees still owing after insurance claims have been processed and remitted.

Client or insured party signature:________________________Date:________