OASIS CHRISTIAN COUNSELING

908 W Chandler Blvd, Suite C-8; Chandler, Arizona 85225

INSURANCE INFORMATION

NAME OF CLIENT _____

CLIENT'S DATE OF BIRTH _____

ADDRESS OF CLIENT_____

CITY_____STATE_____ZIP_____

NAME OF POLICY HOLDER_____

POLICY HOLDER'S DATE OF BIRTH_____

ADDRESS OF POLICY HOLDER_____

_____

PHONE NUMBER OF POLICY HOLDER_____

INSURANCE COMPANY_____

I.D.NUMBER_____

GROUP NUMBER_____

PHONE NUMBER_____

NAME OF EMPLOYER_____

PLEASE SIGN BOTH OF THE FOLLOWING:

AUTHORIZATION TO PAY BENEFITS TO CLINICAL SOCIAL WORKER: I hereby authorize that the Medical Benefits, if any, which would otherwise be payable to me, be paid directly to the undersigned psychotherapist, but are not to exceed the reasonable and customary charge for these services.

Signed_____ _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned psychotherapist to release any information acquired in the course of my examination or treatment that is necessary to process this claim.

Signed _____ Date _____