CLIENT INFORMATION

Today's Date _____

Client's Full Legal Name_____

Address _____City_____ Zip_____

Hm Phone_____ Bus Phone_____ Cell_____

SS# _____ Date of Birth_____

Marital Status:(circle) Partner Married Single Divorced Separated Widowed

Gender: _____Male _____Female Relationship to Insured:_____

If the client is not the insured member please fill out this portion:

Member's Full Legal Name_____

Address _____City_____ Zip_____

Hm Phone_____ Bus Phone_____ Cell_____

SS# _____ Date of Birth_____

Employer_____ Phone No. _____

Insurance Company_____
(If you have Medicare as Primary, please put the Secondary Company on the back of this page)
Claims Mailing Address _____
City_____ State_____Zip_____ Ph#_____

Member ID #_____ Group #_____

Auth#_____ Effective Dates_____ No of visits_____

Deductible $_____ (has this been met? _____yes _____no) Copay $_____

Primary Physician _____ Phone#_____

Major Health Problems/Allergies_____

Medications(dosage/time of day)_____

In case of emergency, notify_____ Phone#_____
CLIENT OR AUTHORIZED SIGNATURE: ***I authorize the release of any medical or other information necessary to process all insurance claims. I also authorize payment of medical benefits to Dr. Libby Howell, Ed.D. for claims submitted on my behalf, and should said claims be denied for any reason I will be responsible for the balance.***

SIGNATURE_____ Date_____
SIGNATURE_____ Date_____