NEW PATIENT INSURANCE INFORMATION

Patient Information

Patient's Name: ____

Address: ____ Apt# _________

City: _________________________________ State: ___________ Zip Code: ___________

Primary Contact# ____________________ Secondary Contact# _____________________

Date of Birth: __________ Social Security# _______________ Employer: ________________

Email Address: ____

Emergency Contact Information

Name: __________________________ Relationship to Patient: ______________________

Primary Contact# _____________________ Secondary Contact# ______________________

Guarantor Information

Guarantor's Name: ____

Address: ____ Apt# ________

City: ________________________________ State: ____________ Zip Code: ___________

Primary Contact# ____________________ Secondary Contact # _____________________

Date of Birth: __________ Social Security# _______________ Employer: ________________

Client or Authorized Person's Signature:
I understand that it is required that I bring to my appointment my Insurance Card and a Photo ID. I understand that some charges may not be covered by my insurance plan and that I may be responsible for payment, in full, of these charges.

____

Signature

I authorize payment of medical benefits to Okapi Counseling and Family Services, PLLC

Signed**______________________________** ***Date*****____________**

I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed**______________________________** ***Date*****____________**

Insurance Information - Page 2

Client Name:

Insurance Company Information -- Primary Coverage

First Name M.I. Last Name ____

Address____

City________________________ State______ Zip___________

Home phone_____________________ Work phone____________________

Policy Holder Information *(complete section below **IF** policy holder is not client - **OR** - copy of card is not present)* :

Birth Date _______________ Gender: M F

Client relationship to Insured: Self Spouse Child Other

Under employer's health plan? *Circle one:* Y N Insured's Social Security # _____ - _____ - _____

Employer Name____________________________________

Ins Co. Name_______________________________________ Phone number ____________

Address____

City______________________________ State______ Zip____________________

ID number _____________________ Group number________________________

Insurance Company Information -- Secondary Coverage

If there is another health benefit plan, complete the following.

Other Insured Information:

First Name M. I. Last Name ____

Birth Date _______________ Gender: M F

Client relationship to Insured: Self Spouse Child Other

Under employer's health plan? *Circle one:* Y N Insured's Social Security # _____ - _____ - _____

Employer Name_____________________________________

Ins Co. Name_______________________________________ Phone number ____________

Address____

City______________________________ State______ Zip____________________

ID number _____________________ Group number________________________