Adult Insurance Information Form

**This information will remain confidential*

_____ (____)_____
Name Phone Number

_____ _____
Social Security Number Date of Birth

_____ (____)_____
Place of Employment Work Phone Number

Income $ _____ per hour # of Exemptions:
Household: _____ Disabled: _____

**Receptionist will make a copy of all insurance cards*

_____ _____
Insurance Company Insurance Policy Number

_____ _____
Subscriber's Name Subscriber's S.S # / Date of Birth

_____ _____
Secondary Insurance Insurance Policy Number

_____ _____
Subscribers Name Subscriber's S.S # / Date of Birth

Insurance Authorization for current or future treatment. This authorization may be cancelled at any time upon my request. I hereby authorize Community Mental Health to apply for benefits on my behalf for covered services rendered by them. I also request that all payments from the agreed third party be made directly to them. I hereby certify that all the information that I have provided to you (including income and insurance) is true to the best of my knowledge. I will report within 14 days of any changes in my income or insurance to the agency. I further authorize the release of any necessary information to the agreed third party for this or related claims. I understand that I will be responsible for any charges incurred by me that are not covered by my insurance up to my ability to pay. Refusal to provide this agency with financial and/or insurance information will result in charging the above mentioned consumer with the full cost of service.

_____ _____
Signature of Patient or Guardian Date

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