INSURANCE INFORMATION

1. **GENERAL INFORMATION**

Name: ____

DOB: ____________________ Age: ________________ Gender: ____________________

Address: ____

____

Contact (please mark with * the best way to reach you):

H ______________________________ W ______________________________

Cell: ____________________________ Email: ____________________________

Emergency Contact (name, phone number, relationship):

____

2. **INSURANCE INFORMATION:**

Name of Insurance Plan: ____

ID #: ____

Fill out the following information ONLY if the primary insured is different from the patient):

Name of Insured: ____

DOB if Insured: ____

Address of Insured: ____

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3. **AUTHORIZATION TO BILL INSURANCE:**

I authorize Cecilia Esquivel, LCSW-C to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed: ______________________________________ Date: ____________________

Name (PRINT): ____