
Please fill in the following information. If you do not know any of the information requested below, please obtain it from your insurance company prior to our first session.

**Primary Insured on the Insurance Plan (Person Responsible for the Bill)**

Name:_____ (as it appears on your insurance card)

Address:_____

City:_____ State: _____ Zip: _____

Date of birth:_____

Home Telephone:_____ Cell number: _____

Employer:_____

Email Address:_____

**Client Information**

Relation to Primary Insured: Self _____ Spouse_____Child_____Other_____ (if same please skip to Insurance Information Section.

Last Name:_____ First Name_____ MI_____

Address:_____

City:_____ State: _____ Zip: _____

Date of birth:_____

Home Telephone:_____ Cell number: _____

Employer/School:_____ State:_____ Zip_____

**Insurance Information**

**Name of Primary Insurance**:_____

ID#: _____ Group #:_____

Name of Plan:_____

Co-Pay Amount:_____

Referral Number (if applicable):_____

Number of visits allowed: _____

**Name of Secondary Insurance** (if applicable)**:**_____

ID#: _____ Group #_____

Name of Plan:_____

Co-Pay Amount:_____

Referral Number (if applicable):_____

Clarity Connection, LLC will copy any insurance card(s) for any insurance you would like for us to bill on your behalf. Please also be sure to obtain any prior authorizations that may be required for your insurance to pay for this and future visits.

**I understand if service is not a covered benefit and that without an authorization/referral form from my HMO/IPA/PPO (if required), I will be financially responsible for charges I incur.**

**Signature of responsible party _____**

**Date:_____**