



POSITIVE FRAME OF MIND  
COUNSELING PLLC

## Insurance & Financial Information

Insurance Company: \_\_\_\_\_

Phone # \_\_\_\_\_

Primary Insured's Name: \_\_\_\_\_

Primary's SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I.D # \_\_\_\_\_

Group # \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_

SSN#: \_\_\_\_\_

Street Address (if different from patient) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Years with Employer: \_\_\_\_\_



POSITIVE FRAME OF MIND  
COUNSELING PLLC

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Secondary Insurance Company**

Secondary Insurance Co: \_\_\_\_\_

Phone #: \_\_\_\_\_

Secondary Insured's Name: \_\_\_\_\_

Secondary SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_  
\_\_\_\_\_