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: _____________________

Martial Status: ____________________________

Employer: ____

Occupation:____

Years with Employer: _________________

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 #___________________________