Keystone

Partner #1's Cell Phone	Partner #2's Cell Phone

PARTNER #1 _____ SS# _____ DOB _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Marital Status _____

Employer _____ Occupation _____

Address _____ Work Phone _____

City _____ State _____ Zip _____

Email _____

PARTNER #2 _____ SS# _____ DOB _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Marital Status _____

Employer _____ Occupation _____

Address _____ Work Phone _____

City _____ State _____ Zip _____

Email _____

INSURANCE COMPANY INFORMATION

Primary _____ Secondary _____

Address _____ Address _____

_____ _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Policy Holder _____ Policy Holder _____

Primary Care Physician _____ Office Phone Number _____

Referring Physician or Agency _____

I understand that I am financially responsible for payment of services received by me or my dependent(s). I authorize the release of clinical or medical information to my insurance company, primary care physician and referral source or agency when needed for insurance coverage and/or payment. I understand that insurance claims will be electronically filed to my insurance carrier on my behalf. I am responsible for payment(s) not received from the insurance company within 90 days of treatment and will make payment to Keystone LLC within 10 days. I assign insurance benefits payable to me to Keystone Counseling & Consulting LLC.

Signature _____ **Date** _____