



Patient's Cell Phone _____	Spouse's Cell Phone _____
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PATIENT _____ SS# _____ DOB _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Marital Status _____
 Employer _____ Occupation _____
 Address _____ Work Phone _____
 City _____ State _____ Zip _____
 Email _____

SPOUSE _____ 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** _____