Dolores (Lolita) B. Grohmann, LMFT
Marriage & Family Therapist-Lic. #MT 1891
Bridgewater Professional Park 4913 Van Dyke Rd
Lutz, Fl 33558 (813) 924-3491

Client Health Insurance Information Form

Please complete and sign this form. Present your insurance card to your therapist. A copy of your card is required.

Client Last Name:_____ First Name:_____

Social Security Number:_____ Date of Birth: _____ Age:_____

Sex: M F Marriage status: Single Married Other Employment status: Employed Student Unemployed

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we contact you at Home? ____Yes ____No Cell? ____Yes ____No Work? ____Yes ____No

Occupation: _____

Primary Insured (if different from above)

Last Name:_____ First Name:_____

Social Security Number: _____ Date of Birth:_____

Employee Assistance Program (EAP) Information (if applicable):

EAP Company: _____

Phone: (____)_____ Authorization No/# Sessions Auth: _____

Employer: _____

Mental/Behavioral Health Insurance Information:

Insurance Company: _____

Ins. Mailing Address: _____

_____

_____

Phone: (____)_____ Client ID Number: _____

Authorization No/# Sessions Auth: _____ Group Number: _____

Copay amount: _____ Deductible amount: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Dolores B Grohmann, LMFT. I authorize payment of medical benefits to Dolores B Grohmann, LMFT for services described on HCFA/CMS 1500 form.

_____

Insured/Guardian Signature Date