Client Information

Client Name: ____ DOB: ____________________

Address: ____

Phone: _________________ Occupation: ______________ SSN: _____________ Gender: _______

Marital Status: ___________ Spouse's name: ____

Responsible party:

Name: ____ DOB: __________________

Address: ____ Phone: ________________

I agree to pay the fees incurred by this client in a timely fashion. ________________________________

signature of responsible party

Primary Insurance:

Name of insured: ____ DOB: _______________

Company: ____________________________ Phone #: ____________________________________

Group #: _____________________________ Individual #: __________________________________

Secondary Insurance:

Name of insured: ____ DOB: _______________

Company: ____________________________ Phone #: ____________________________________

Group #: _____________________________ Individual #: __________________________________

To the best of my knowledge, all insurance information has been provided on the above form. I authorize release of any medical information needed to process this claim. I hereby authorize payment of medical benefits to Sage Behavioral Counseling. I authorize Sage Behavioral Counseling to represent me, if needed, before the Oregon Insurance Commissioner. I understand that I am financially responsible for any charges not covered by insurance and for cancellation with less than 2- 24 hours notice prior to appointment

____ ______________________

client signature date

Sage Behavioral Counseling, LLC

1011 SW Emkay Dr, Suite 101, Bend OR 97702
541.668.6873

Client Information

Office Use Only:

Provider: ____ DX: ____________________

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