INSURANCE INFORMATION FORM

Date: ______________________

Client's Name: ____
First | Middle name | Last

Client's DOB: ______________________ Age: _______ Social Security #:_______________________

Gender (M/F/Transgender/other)______________ If other Specify:_____________ Marital Status:______

Address: ____
Number/Street | City | State | Zip

Telephone Numbers:

Home: (   )______ - _________Work: (   )______ - _________ Cell: (   )______ - _________

HEALTH INSURANCE INFORMATION:

1. Insurance Company Name: ____

   a. Plan Name:____
   b. ID #:_________________________ Group #: ________________________________
   c. Plan Phone #:____
   d. Policy Holders' Name:_____________________________DOB:___________________
   e. Policy Holder's Employer: ____

2. Secondary Insurance Company Name: ____

   a. Plan Name:____
   b. ID #:_________________________ Group #: _____________________________________
   c. Plan Phone #:____
   d. Policy Holders' Name:_____________________________DOB:______________________
   e. Policy Holder's Employer: ____

3. Medicaid: Yes ☐ No ☐ ID #____________________________________

Excluding exceptional circumstances, clients will be bill at the current cancellation fee for appointment not cancelled 24 hours in advance.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered. I have read all the above information and have completed the above answers. I certify this information is true and correct to the best of my knowledge.
I will notify you of any changes in the above.

I agree to make available any documentation and further authorize Seashore Family Services of NJ to check any information provided.

Note: if you are requesting services for substance abuse and you want to use your insurance, an additional release of information is required. Please contact us at Chambers Bridge Rd office, 732-920-2700, Beaverson Blvd Office, 732-477-3507 or at Toms River office 732-244-1600 or email us at: info@sfsnj.org.

____ ________________________________

Client Signature Date Client's Name (print)

____ ________________________________

Client's parent Signature Date Parent's Name (print)
(if client is a minor)