



## Client Insurance Information

### Primary Insurance information:

Insured \_\_\_\_\_  M  F Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Insured SS# \_\_\_\_\_  
Ins. Co. \_\_\_\_\_ Group# \_\_\_\_\_ Phone \_\_\_\_\_

If primary insured does not live in household:

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

### Secondary Insurance Information:

Insured \_\_\_\_\_  M  F Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Insured SS# \_\_\_\_\_  
Ins. Co. \_\_\_\_\_ Group# \_\_\_\_\_ Phone \_\_\_\_\_

If secondary insured does not live in household:

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

We will need a copy of the front and back of your insurance card(s). Please notify us if there is any change expected to your insurance and give us your new card when you receive it.

### In order to use your health insurance, please sign below:

In accordance with the **Legacy Clinical Consultants'** Notice of Privacy Practices, I authorize **Legacy Clinical Consultants, LLC** to release any medical information to my managed-care and/or insurance company which may be deemed necessary in order to process an insurance claim. I understand I am financially responsible for all charges and it is my responsibility to know my own insurance plan.

Client Signature: \_\_\_\_\_  
(12 years of age and older)

Parent/Guardian Signature: \_\_\_\_\_