STEFANIE M. BROWN, JD MA LMFT CACI
LICENSED MARRIAGE & FAMILY THERAPIST

PTSD TRAUMA TREATMENT CENTER
TRADITIONAL AND EQUINE-ASSISTED PSYCHOTHERAPY

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www.OperationNewNormal.com

Client Insurance Information & Release

Client: _____

Date of Birth: _____

SS#: _____

Address: _____

_____

Phone: (h)_____

(c)_____

Marital Status: S M D W Other

Employer: _____

Sponsor Name: _____

Date of Birth: _____

SS#: _____

Address: _____

_____

Phone: _____

Relationship to Client: _____

Marital Status: S M D W Other

Employer: _____

Primary Insurance: _____

Insurance ID#: _____

Group #: _____

Secondary Insurance Info: _____

Address for Claims: _____

_____

Phone (benefits) _____

Phone (precertification) _____

I authorize this office to release any information obtained during my examination or treatment that is necessary to expedite and support any insurance claims on this account. I understand that I am responsible for all changes regardless of insurance coverage. I authorize payments to be made directly to Stefanie Brown.

_____ _____
Signature of Client Date

_____ _____
Updated (at a later date) Later Date