SafeCare
Counseling Services

Patient Billing and Registration Form

Please have insurance cards present and complete this form.

*Patient Name:_____ *Guarantor Name:_____

Date of Birth:_____ Date of Birth:_____

Social Security #:_____ Social Security #:_____

Street Address:_____ Street Address:_____

City, State, Zip:_____ City, State, Zip:_____

Phone Number:_____ Phone Number:_____

Insurance Information:

*Primary
Insurance Name:_____ Policy Holder Name:_____
Street Address:_____ City, State, Zip:_____
Date of Birth:_____ Social Security #:_____

Policy Number:_____ Group #:_____
Employer:_____

*Secondary (if applicable)
Insurance Name:_____ Policy Holder Name:_____
Street Address:_____ City, State, Zip:_____
Date of Birth:_____ Social Security #:_____

Policy Number:_____ Group #:_____
Employer:_____

I agree that the therapist billing department is authorized to submit insurance claims and follow up on insurance payments on behalf of my therapist.

Signature:_____ Date:_____