the blossom method

INSURANCE DATA FORM

Today's Date:_____

Client Name:_____Date of Birth:_____

Adress:_____
_____

Telephone:
Home:_____
Work:_____
Cell:_____

Social Security #:_____

Who referred you?_____

Name of Employer or School:_____
Employer or School's
Address:_____
_____
_____

Occupation:_____

Name of Insurance Company:_____
Name of Managed Care Company:_____
Billing Address:_____
_____
Insurance ID number:_____
Insurance Group or Policy Number:_____
Authorization or Referral Number:_____
Marital Status:_____
Employment Status:_____
Relation to Insured (circle one): Self Spouse Dependent Other

233 E. Erie Street #306
Chicago, Illinois 60611
312.854.0061
www.theblossommethod.net

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If you are not the insured party, please complete the following for the insured:

Name of the insured:_____

Address:_____

_____

Telephone: home:_____work:_____

Insured's Social Security Number:_____

Insured's Date of Birth:_____

Insured's Insurance ID Number:_____

Group or Policy Number:_____

Insured's Employer:_____

Address of Insured's Employer:_____

I authorize The Blossom Method to release such information to my insurance company as is necessary to support the insurance claims filed on my behalf. I understand that I am responsible for all charges regardless of insurance coverage.

I understand that I can cancel an appointment, without charge to me, provided that I do so at least 24 hours in advance. I agree to pay the full fee for sessions I miss without 24 hours' notice, and I am aware that such missed appointments cannot be billed to my insurance company.

Signature:_____

I authorize the payments of benefits directly to The Blossom Method.

Signature:_____

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