Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Home or Cell Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Referring/Ordering MD Information, if applicable

Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information

Policyholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder’s DOB:\_\_\_/\_\_\_/\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_ Insurance Company Name:\_\_\_\_\_\_\_

Policy/Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization to contact health insurance carrier, and release confidential medical information:

I authorize the disclosure of insurance benefit coverage and payment information to Kristin Leonheart, M.S., LMFT. I authorize Kristin Leonheart, M.S., LMFT to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Authorization to assign benefits, and accept financial responsibility for my account:

I assign and authorize insurance payments to Kristin Leonheart, M.S., LMFT. I understand that my insurance carrier may not approve and reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where limited by contract or State or Federal law.

Signature of Client or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Client or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_\_/\_\_\_\_