Jody Fixman Hansen, LLC
Client Information/Insurance Form

Date: ________________________

Contact Information:

Client Name: _____________________________________ M F

Home Address: ____

Home Telephone Number ( ) _____________________ Is it okay to leave message? Y N

Work Telephone Number ( ) _____________________ Is it okay to leave message? Y N

Cell Telephone Number ( ) _____________________ Is it okay to leave message? Y N

Social Security #:______________________ Date of Birth: ________________ Age: _______

Personal Status: Married: ___ Single: ___ Widowed: ___ Divorced: ___ Partner: ___

Employment Status: Employed: ____ Student: ____ Unemployed:____ Retired:____ Other:_____

Financial Responsibility (Client is responsible for payment at the time of service):

Employer: ______________________________ Occupation: _____________________

Will you be using insurance for service? Y N

Person responsible for deductible, coinsurance, and co-payments, if other than client:

Name: ____

Address: ____

Deductible/year: $_____________ Has it been met? Y N

Co-payment/coinsurance per visit: $____________ or __________%

Did you receive an authorization/pre-certification number from your insurance company? Y N

Authorization/pre-certification #: ___________________________ No. of visits: _____________

Did you get a referral from your Primary Care Physician, if required by insurance? Y N

Did you let your insurance company know you had an appointment? Y N

Insurance Co. Name :______________________________ Contact Phone:___________________

Policy Holder's Name: ____________________________ Relationship to Client:______________

Policy Holder's ID#: _______________________________ Group #: _______________________

Policy Holder's Date of Birth: ____________________