Legacy Clinical Consultants, LLC

Transforming Lives, Impacting the Future

Client Insurance Information

Primary Insurance information:

Insured _____ ☐ M ☐ F Date of Birth _____

Employer _____ Insured SS# _____

Ins. Co. _____ Group# _____ Phone _____

If primary insured does not live in household:

Address _____

City _____ State _____ Zip _____ Phone _____

Secondary Insurance Information:

Insured _____ ☐ M ☐ F Date of Birth _____

Employer _____ Insured SS# _____

Ins. Co. _____ Group# _____ Phone _____

If secondary insured does not live in household:

Address _____

City _____ State _____ Zip _____ Phone _____

We will need a copy of the front and back of your insurance card(s). Please notify us if there is any change expected to your insurance and give us your new card when you receive it.

In order to use your health insurance, please sign below:

In accordance with the **Legacy Clinical Consultants'** Notice of Privacy Practices, I authorize **Legacy Clinical Consultants, LLC** to release any medical information to my managed-care and/or insurance company which may be deemed necessary in order to process an insurance claim. I understand I am financially responsible for all charges and it is my responsibility to know my own insurance plan.

Client Signature: _____

(12 years of age and older)

Parent/Guardian Signature: _____

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