Michele M Freeman, MS, NCC, LPC
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Phone 541-408-4943 • Fax 541-330-1951
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INSURANCE BILLING INFORMATION CLIENT INFORMATION

Full Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ SSN: _____
Relationship Status: _____ Primary Care Physician: _____

PRIMARY INSURANCE

Name of Insurance: _____ Phone: _____
Claims Address: _____ Email/Web: _____
Subscriber Number: _____ Group Number: _____
Insured Holders Info (if other than self)
Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
SSN: _____ Relationship to Insured: _____

SECONDARY INSURANCE (If Applicable)

Name of Insurance: _____ Phone: _____
Claims Address: _____ Email/Web: _____
Subscriber Number: _____ Group Number: _____
Insured Holders Info (if other than self)
Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
SSN: _____ Relationship to Insured: _____

ASSIGNMENT OF BENEFITS

I hereby assign to Michele Freeman any insurance or other third-part benefits available for health care services provided to me. I understand that Michele Freeman has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Michele Freeman, I agree to forward to Michele Freeman all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

How will you pay for this visit today? Cash _____ Check _____ Other _____