T.C.I. Therapy, LLC

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INSURANCE INFORMATION AND DESCRIPTION OF CONCERNS

Client's name: _____
Date of birth: _____
Address: _____
Client or guardian contact email address: _____
Client or guardian contact phone number: _____

Primary insurance: _____
Sponsor ID, Benefits #, or Member ID #: _____
Policy holder's name and DOB if not client: _____
Phone number from back of card: _____

(Leave blank if client does not have a secondary insurance)
Secondary insurance OR EAP information: _____
Sponsor ID, Benefits #, or Member ID #: _____
Policy holder's name and DOB if not client: _____
Phone number from back of card: _____

Brief description of the reason for seeking counseling/therapy services: _____