

# Insurance & Billing Information

Fillable · Complete and email to Robert

Type directly into each field. Click 'Submit by Email' when complete. (503) 383-9144 · robert@branching-streams.com

## CLIENT INFORMATION

Client Full Name

Date of Birth

Phone

Email

## PRIMARY INSURANCE

Insurance Company Name

Plan / Group Name

Member ID Number

Group Number

Effective Date

Primary Insured Name (if different)

Primary Insured Date of Birth

Primary Insured Employer

Relationship to Client

## SECONDARY INSURANCE (if applicable)

Secondary Insurance Company

Member ID Number

Group Number

## CREDIT CARD ON FILE

Cardholder Name (exactly as on card)

Card Number

Expiration (MM/YY) / CVV / Card Type

## AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Branching Streams Psychotherapy, LLC to bill my insurance and receive payment directly. I authorize my card to be charged for any co-pay, deductible, or balance not covered. I understand I am ultimately responsible for all fees.

Client / Guardian Signature (type name)

Date

**Submit by Email to Robert**

Clicking opens your email app — attach completed PDF and send to robert@branching-streams.com