Your Personal Information

Name: First______________________________ M.I. ______________ Last _________________________

Phone: Home________________________ Work____________________ Cell _____________________

Where can I leave a message Home ____ Work ____ Cell ___

email address_________________________________

Address:____

City _________________________________ State _______ Zip Code _______________________

Sex: ❑ male ❑ female Birth date: _____________________________________

Social Security Number: XXX-XX-________________

Employer

Employer Name____

Address:____

City _________________________________ State _______ Zip Code _____________________

Insurance Information

Marital Status ❑ single ❑ married ❑ divorced ❑ other
Employment Status: ❑ full-time ❑ part-time ❑ retired ❑ not employed
Student Status ❑ full-time ❑ part-time ❑ non-student
Will your treatment be covered by an EAP program? ❑ yes ❑ no
If yes, name of EAP and contact person ____

Policy Holder :

Insurance #1: Insurance #2:

Claims Mailing Address	Claims Mailing Address
Insured Party	Insured Party
Marital Status	Marital Status
Date of Birth	Date of Birth
Policy #	Policy #
Group #	Group #
Employer (please provide address if different than above)	Employer (please provide address if different than above)

Patient's or authorized person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party below:

Signed____ Date: ____________________

Insured or Authorized Person's Signature: I authorize payment of medical benefits to Natural Resilience, LLC for services:

Signed____ Date: ____________________