resilient kids

integrative counseling for children & adolescents

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: _____