CHANGE OF INSURANCE FORM

Client Name:_____ Date:_____

Date Effective:_____

Insurance Company:_____

Plan Type (i.e., HMO, PPO):_____ Copay:_____

Insurance Identification Number (all characters):_____

Subscriber's Name:_____ D.O.B.:_____

Subscriber's Employer:_____

Relationship to Client:_____

Physician Name:_____

Physician's Phone/Address:_____

_____

Authorization #_____

Parent/Guardian/Client Signature to Bill Insurance: X_____

Date:_____