Sterling Behavioral Health Associates, LLC

9800 Northwest Freeway, Suite 206

Houston, Texas 77092

Insurance Company Information

Name of Client:_____**Date of Birth**_____

Ins. Co. Name:_____**Phone #**_____

Policy/ID:_____**Group #**_____

Policy Holder Info: (***Please complete below IF policy holder is not client***)

Policy Holder Name:_____**Date of Birth**:_____

Address:_____**Phone** #_____

Employer:_____**Gender** ____**Male** _____**Female**

Social Security #_____

Client relationship to Policy Holder_____

Secondary Insurance Company Information:

Ins. Co. Name:_____**Phone** #_____

Policy/ID:_____**Group** #_____

Employee Assistance Program:

Ins. Co. Name:_____**Phone Number**:_____

Authorization #_____**# Sessions Auth**._____**Expire**_____

If no insurance or EAP, how will you pay for services?_____

Signature:_____**Date:**_____

Printed Name:_____