**INTERNATIONAL CONSULTING CENTER, PLLC**

Behavioral Health Services

828 25th Street N.W. 1765 Greensboro Station Place

Tower II 9th Floor

Washington, DC 20037 McLean, VA 22102

Phone: 202-787-3843/ 703-255-1600

**INSURANCE DATA SHEET** Date: Appointment Day

|  |  |  |  |
| --- | --- | --- | --- |
| Name: First Name Last Name | | | |
| Date of Birth: MM/DD/YY | | Social Security Number (last 4 digits):#### | |
| Address: Address | | | |
| City: City | State: Select State | | Zip Code: ZIP |
| Cellphone: Cellphone # | Office/Home Phone (home):Phone Home | | |
| e-mail: e-mail | | | |
| Name/Phone (emergency contact): Name of Contact and Phone Number | | | |
| Name of employer: Name of employeer | | | |
| Occupation: Occupation | | | |

|  |  |
| --- | --- |
| Name of Insurance Company: Name of Insurance Company | |
| ID: ID Number | Group: Group |
| Patient relationship to Insured: | |

|  |
| --- |
| EAP Name: WP/EAP/Anthem/Aetna …. |
| Authorization Number: Auth # |

|  |  |  |
| --- | --- | --- |
| Name of other members of household | | |
| Name: Name | DoB: MM/DD/YY | Relationship: Relationship |
| Name: Name | DoB: MM/DD/YY | Relationship: Relationship |

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_