Client Name: ________________________________
Client Date of Birth: ___________________________

Insurance Information

Clouse Counseling, LLC/Wildflowers Counseling
Noelle W. Clouse, LMHC
Email. noellewclouse@wildflowerscounseling.com

Client Name: ____ DOB: ____________

Client Social Security Number: ___________________________________ Gender: _______________

Primary Insurance

Primary Insurance Company: ____________________________________ (Behavioral Health)

Account Number: _____________________________ Group Number: _______________

CoPay for Behavioral Health Care: _______________________
Individual Deductible ____________________Family Deductible ______________________
Has the deductible been met? __________

Account Holder: ________________________________Relationship to Client: _____________
DOB of Account Holder: _______________ SSN of Account Holder: ____________________
Address: ____ Primary
Phone: _______________________________ Type of Phone: ____________________

Employer: ____
Employer Address: ____
Employer Phone: ___________________________ Occupation: ________________________

Secondary Insurance (if applicable)

Primary Insurance Company: ____________________________________(Behavioral Health)

Account Number: _____________________________ Group Number: _______________

CoPay for Behavioral Health Care: _______________________
Account Holder: ________________________________Relationship to Client: _____________
DOB of Account Holder: _______________ SSN of Account Holder: ____________________
Address: ____

Primary Phone: _______________________________ Type of Phone: ____________________
Employer: ____
Employer Address: ____

Employer Phone: ______________________________ Occupation: ___________________________