

**KIMBELRY LAPLUME, LMFT
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INSURANCE REGISTRATION AND AUTHORIZATION

Client: _____ Date of Birth: _____
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Address: _____

Phone Number: _____ Full Time Student: Yes _____ No _____

Employer's Name or School Name: _____

Insurance Company: _____ Ins Mental Health phone number: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____ DOB: _____

Social Security Number: _____ Phone Number: _____

Insured's Address: _____

Insured's Relationship to Client: _____

Insured's Employer: _____

Is there other insurance coverage: Yes _____ No _____

If yes, Name of Insured: _____

Insurance Company: _____

Policy Number: _____ Group Number : _____

Release and Payment Authorization:

By signing below I authorize the release of any medical or other information necessary to process claims for payment of services provided by Kimberly LaPlume, LMFT.

Client or Authorized Person's Signature Date

By signing below I authorize payment of benefits to Kimberly LaPlume, LMFT

Client or Authorized Person's Signature Date