



Credence Therapy Associates  
1 ½ West Geneva Street  
Elkhorn, WI 53121  
(262)723-3424

**Insurance Information**

Client Name \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

Subscriber or Customer#: \_\_\_\_\_ Group#: \_\_\_\_\_

☐ No secondary Insurance

**Secondary Insurance Company:** \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_

Subscriber or Customer#: \_\_\_\_\_ Group#: \_\_\_\_\_

I understand by signing below that all information is correct and accurate to the best of my ability. I except responsibility for all charges rendered and that billing my insurance company is a courtesy. I agree to contact Credence Therapy Associates if my address, phone number, insurance, or any other changes occur at the time I am seeking services.

\_\_\_\_\_  
Patient Signature (18years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (17years or younger)

\_\_\_\_\_  
Date

PLEASE BRING CARD TO FIRST SESSION OR MAKE COPY FOR OUR RECORDS