INTAKE
VCAT TREATMENT CENTER LLC.
Psychological Services

Member ID: NS_____

Name: _____ Date: _____

Address: _____ Gender: M F

City : _____ State: _____Zip:_____ Date Of Birth:_____ Age:

Cell :_____

Insurance Information

Primary Health Insurance: _____

Subscriber Name:_____ Relationship to Subscriber:_____

ID Number: _____

Authorization for Release of Insurance Information

I hereby authorize VCAT Treatment Center LLC., or its authorized staff to contact my insurance company directly to obtain coverage and payment information regarding my policy.

_____

X _____

Signature