FamilyAttachment

COUNSELING CENTER

Client Insurance Information

Client Name: _____ Male Female

Please circle last name

Address: _____

Date of Birth: _____

Home Telephone: _____ Work Telephone: _____

Primary Insurance: _____

Name of insured: _____ Date of Birth: _____
(if other than client)
Insurance Address: _____

Insurance Phone: _____

ID and Group #: _____

Secondary Insurance: _____

Name of insured: _____
(if other than client)
Insurance Address: _____

Insurance Phone: _____

ID and Group #: _____

Authorization to Bill Insurance

I understand that full payment of all charges is my responsibility. I authorize Family Attachment and Counseling Center to bill my insurance company for all appropriate charges. I understand that any applicable co-payment and deductible are due at the time services are rendered. I authorize my insurance company to make payment of medical benefits to Family Attachment and Counseling Center for appropriate services.

_____ _____

Authorized Signature Date