Insurance Information Sheet

If you are planning to use health insurance for your visits, please complete this form in its entirety. If you do not plan to use insurance or do not have insurance, please skip this form.

Please fill out all fields to the best of your abilities, if you are having trouble or are unable to gather any of the requested information, please reach out to our office staff.

CLIENT INFORMATION:

Name (exactly as it appears on card):____________________ DOB:_____/_____/_________

Social Security Number: _______-_______-_______ Phone: ____________________

PRIMARY INSURANCE POLICY:

Please fill out the following fields for the primary policyholder

Legal Name: ______________________ Employer:____

Relation to Client: ___________________ DOB:_____/_____/_________ Phone:_______________

Social Security Number: _______-_______-_______ Streed Address:_____________________________

City:____________________________ State:________ Zip:____________

Please fill out the following exactly as it appears on your insurance card

Insurance Company:_____________________ Plan Type:___________ Group Number:___________

Policy Number/Member Id:_____________________________ *(all letters & numbers)*

Number for Claims (on back of card):_____________________

Street Address for claims:______________________ City:_____________ State:___________

Zip:______________

SECONDARY INSURANCE POLICY:

______ I DO HAVE A SECONDARY INSURANCE POLICY (*fill out the information below)*

_____ I DO NOT HAVE A SECONDARY INSURANCE POLICY (*proceed to next section of the form)*

Please fill out the following fields for the primary policyholder

Legal Name: ______________________ Employer:____

Relation to Client: ___________________ DOB:_____/_____/_________ Phone:_______________

Social Security Number: ______-______-______ Streed Address:______________________________

City:_____________________________ State:________ Zip:____________

Please fill out the following exactly as it appears on your insurance card

Insurance Company:_____________________ Plan Type:___________ Group Number:___________

Policy Number/Member Id:_____________________________ *(all letters & numbers)*

Number for Claims (on back of card):_____________________

Street Address for claims:______________________ City:_____________ State:___________

Zip:______________

By providing this information, I am consenting to Counseling Associates for Well-Being, on behalf of my clinician, verifying my benefits and coverage. I am giving permission for Counseling Associates for Well-Being and the above-listed clinician, to disclose my information for the purposes of billing my insurance plan. I understand that, if my coverages or benefits change, I must notify my clinician right away. My clinician cannot bill for services or make changes retroactively. I also agree and understand that I will be responsible for the payment of any co-payments, co-insurance payments, deductible amounts, or fees for any non-covered services.

SIGNATURE:________________________________ DATE:_________________________