INSURANCE INFORMATION

Name of Insurance Company _____

Name of Insured (policy holder) _____

Does policy holder reside with client? Y _____ N _____ if no, provide policy holder address

Insured's Address _____

Insured's Date of Birth _____

Name of Client (person(s) being seen for treatment) _____

Client's Date of Birth _____

Insured's SSN _____ Client's SSN _____

Group Number _____

Member Number _____

Insurance Co. Phone Number _____

Insurance Co. Billing Address _____

_____

Insured Employed By _____

Employer's Phone Number _____

Employer's Address _____

By signing here, you authorize Heather Williams, LMFT, to bill and release information to your insurance company.

Print Name _____ Signature _____ Date _____