GUIDING PATHS
COUNSELING

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Insurance Information

Client Name: ______________________________ DOB: ______________

Primary Insurance: ______________________________

Insurance Phone Number: ______________________________

Insurance Address: ______________________________

Policy Holder's Name: ______________________________

Relationship to Client: Self Spouse Child Other

Policy Number/ID: ____________________ Group Number/ID: ______________

Copayment: $__________ Deductible: $__________ Coinsurance: __________

Secondary Insurance: ______________________________

Insurance Phone Number: ______________________________

Insurance Address: ______________________________

Policy Holder's Name: ______________________________

Relationship to Client: Self Spouse Child Other

Policy Number/ID: ____________________ Group Number/ID: ______________

Copayment: $__________ Deductible: $__________ Coinsurance: __________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Katie Frazee, of Guiding Paths Counseling, and the insurance companies listed above, to release any information required to process my claims.

______________________________ ______________
Client or Guardian Name (Print) Date

______________________________ ______________
Client or Guardian Signature Date

______________________________ ______________
Clinician's Signature Date