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Insurance Information

Client Name: ____ DOB: _____________________

- Please check this box if you are uninsured

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. I understand that if I am uninsured, it is my responsibility to tell my provider immediately upon receiving insurance benefits. If I fail to inform my provider upon receiving insurance benefits, I agree to pay any uninsured rates previously agreed upon between myself and my provider.

____ ____________________________
Client or Guardian Name (Print) Date

____ ____________________________
Client or Guardian Signature Date

____ ____________________________
Clinician's Signature Date