INSURANCE INFORMATION

Name of Insurance Company_____

Name of Insured_____

Insured's Date of Birth_____

Name of Client_____

Client's Date of Birth _____

Insured's SSN_____ Client's SSN_____

Group Number_____

Member Number_____

Insurance Co. Billing Address_____

_____

Insurance Co. Phone Number _____

Insured Employed By_____

Employer's Phone Number_____

Employer's Address_____

By signing here, you authorize Jennifer Hill, LPCC, to bill and release information to your insurance company.

_____ _____ _____

Print Name *Signature* *Date*