Counseling and Trauma Services, LLC

Insurance Information

Client Name:_____ Date_____

Birth Date _____ Therapist:

Address _____ Email _____

_____ Social Security # _____

Home Phone # Cell Phone #

Emergency Contact Person _____
Relationship to client _____
Phone # for contact _____

Work Phone # Employer:

***Insurance Co. *Policyholder Name**

***Insurance ID# *Policyholder DOB**

***Group #**

For Office Use Only:

Insurance Co. Ph# _____ Claim Address

_____

Reps Name_____ Date_____ Time_____ _____

_____

Effective Date of Policy _____ CAL or Contract Yr (circle one)

Deductible Amts: Indiv. _____/ Family _____ Coinsurance% _____

Copay: _____ Out of pocket met _____ Fee Sched. Amt. _____

Visit Limits _____ Authorization Info: _____