



Center for Counseling
Financial Information

Name of Client: Last First MI Birth Date
SSN Phone: Cell Home Work
Address City State Zip

Person Insured: Last First MI Birth Date
SSN Phone: Cell Home Work
Address City State Zip

Employer of Person Insured

Responsible Party (if not the client): Last First MI Birth Date
SSN Phone: Cell Home Work
Address City State Zip

Claim for Secondary Insurance is the Responsibility of the Client

FOR OFFICE USE ONLY:

Primary Insurance or other Third Party Payer
Address City State Zip
Phone Fax Contact Person
Policy # Group#

Is the person served covered by the insurance? Yes No Effective Date
Deductible Amount \$ Deductible Remaining \$ Coinsurance: Insurance% Client%
Managed Care Co-pay \$

Policy Limits: Sessions: Per CY Per Lifetime Dollar Limit

Pre-Authorization Needed Yes No Pre-Authorization Obtained Yes No Date:

Referral Needed Yes No Referral Obtained Yes No

Types of Service Covered: Individual Group Couples Family Testing

Types of Providers Covered: LCPC LCSW LMFT ALMFT

Supervision Requirements? Yes No (explain)

Additional comments:

[] Called Insurance Date [] Notified Client Date [] Entered Date