

# Connections Counseling, LLC

Shawna Ragan, M.S., LPC  
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## Insurance Information

Client's Name Last:                      First:                      MI:			Client's DOB:		Client ID:
<b>Primary Insurance Company:</b>				Insurance Phone:	
Claims Address:					
Insurance ID Number:		Insurance Group Number:		Effective Date:	
Client's relationship to Policyholder:					
Policyholder's Name Last:                      First:                      MI:			Policyholder's DOB:		Policyholder's Gender: Female                  Male
Policyholder's SSN:			Policyholder's Phone Number:		
Policyholder's Employer:					
<b>Secondary Insurance Company:</b>				Insurance Phone:	
Claims Address:					
Insurance ID Number:		Insurance Group Number:		Effective Date:	
Client's relationship to Policyholder:					
Policyholder's Name Last:                      First:                      MI:			Policyholder's DOB:		Policyholder's Gender: Female                  Male
Policyholder's SSN:			Policyholder's Phone Number:		
Policyholder's Employer:					

The above information is true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to Connections Counseling, LLC/Shawna Ragan, M.S., LPC. I understand that I am responsible for any balance not covered by insurance. I also authorize Connections Counseling, LLC/Shawna Ragan, M.S., LPC or the above identified companies to release any information required to process my claims.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_