Connections Counseling, LLC

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Insurance Information

Client's Name Last: First: MI:		Client's DOB:	Client ID:
Primary Insurance Company:			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:			
Secondary Insurance Company:			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: _____