

# Stacy Smith Counseling LLC

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## INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscribers Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from client): \_\_\_\_\_

Plan Name: \_\_\_\_\_

Policy (ID) Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Phone Number on back of Insurance Card: (\_\_\_\_) \_\_\_\_\_

Client's relationship to subscriber: \_\_\_\_\_

I hereby authorize Stacy Smith to submit all out-of-network claims to my insurance provider. I further authorize Stacy Smith to release any information necessary to process insurance claims, including protected healthcare information.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_