Stacy Smith Counseling LLC

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INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscribers Date of Birth: _____/_____/_____

Address (if different from client): _____

Employer: _____

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: _____