



HIGHER HEIGHTS COUNSELING SERVICES

"Equipping Individuals, Couples, and Families... Soar to Unlimited Possibilities"

Insurance Authorization & Registration

Client Information

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Soc. Security: _____ D.O.B.: _____ Ph No.: _____

Provider Information

Insurance Provider: _____ Effective Date: _____ Ph No.: _____

Policy Holder _____ Relationship _____

Soc. Security: _____ D.O.B.: _____ Ph No.: _____

Employer: _____ Policy No.: _____ Group No.: _____

Contract No.: _____ Co-Pay: Y/N _____ Deductible: _____

2nd Provider Information

Insurance Provider: _____ Effective Date: _____ Ph No.: _____

Policy Holder _____ Relationship _____

Soc. Security: _____ D.O.B.: _____ Ph No.: _____

Employer: _____ Policy No.: _____ Group No.: _____

Contract No.: _____ Co-Pay: Y/N _____ Deductible: _____

Add'l Information:

Flex Spending Account: Y/N _____ Available Allowance _____

(Client or Guardian Printed Name)

(Client or Guardian Signature)

(Date)

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