Counseling Associates of Lake Mary

Individual, Family, & Couples Counseling

INSURANCE NFORMATION

***Primary Insurance:** _____

ID #: _____ Group #: _____

Phone #: (_____)_____-_____ Effective Date: _____/_____/_____

***Secondary Insurance:** _____

ID #: _____ Group #: _____

Phone #: (_____)_____-_____ Effective Date: _____/_____/_____

*Subscriber Name: _____ *DOB: _____/_____/_____

Subscriber's SSN: _____-_____-_____

***IF PATIENT IS A MINOR, NAME OF PARENT/GUARDIAN SIGNING PAPERWORK AND SOCIAL SECURITY #**

Name: _____ DOB: _____/_____/_____

Social Security #: _____-_____-_____ Phone #: (_____)_____-_____

Employer: _____ Position: _____

Office Use Only:

Yearly Max Visits:	Authorization Needed?	If yes, Auth Info:
Deductible:	Amount Met:	Amount Left:
Co-Insurance:		
1st Co-Pay:	2nd Co-Pay:	3rd Co-pay:
Claims Address:		

****I VERIFY THAT THE INFORMATION ON THIS PAGE IS CURRENT & ACCURATE.**

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE