Piedmont Counseling & Development Services, PLLC

Financial and Insurance information:

Billable party: _____

Relationship to client: _____

Address Street _____

City _____ State _____ Zip _____

Phone #: _____

Client's relationship to primary insured: ❑SELF ❑SPOUSE ❑PARTNER ❑CHILD ❑OTHER

Primary Insured's name (if different from above): _____

Address Street _____

City _____ State _____ Zip _____

Birthdate:_____ ❑MALE ❑FEMALE ❑TRANSGENDER

Insured's social security #:____-____-_____

Primary insured's employer:_____

Primary Insurance: _____

Primary Insurance I.D. #:_____ Group #: _____

Secondary Insurance: _____

Secondary Insurance I.D. #:_____ Group #: _____

PATIENT'S, INSURED'S, OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any medical or other information necessary to process all claims for the client described above. I also request and assign payment of insurance, medical, and or government benefits to Piedmont Counseling & Development Services, PLLC.

_____ _____

Signature Date

4917 Piedmont Pkwy, Suite 104, Jamestown, NC 27282 * Phone: (336) 493-5600 * Fax: (888) 908-7050
Moniquec@piedmontlifesolutions.com