Pathways TO THE Heart
SEXUALITY, INTIMACY & RELATIONAL THERAPY

INSURANCE INFORMATION

DATE:_____

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

CLIENT NAME: _____ DATE OF BIRTH:_____

INSURANCE COMPANY NAME:_____

THROUGH EMPLOYER (IF SO NAME OF EMPLOYER):_____ THROUGH SELF: _____

INSURANCE COMPANY'S ADDRESS:_____

MEMBER ID NUMBER: _____GROUP ID NUMBER:_____

EFFECTIVE DATE: _____CO-PAYMENT (IF APPLICABLE)_____

NAME OF POLICY HOLDER (IF OTHER THAN SELF)_____POLICY HOLDER'S DOB_____

ADDRESS OF POLICY HOLDER_____

RELATIONSHIP OF POLICY HOLDER TO CLIENT ☐ Spouse ☐ Child ☐ Other _____