

**Insurance Authorization - ADULT**

**I. Client**

Last Name	First Name	Date of Birth
Address		
City	State	Zip
Phone #1	Phone #2	

**II. Subscriber (If different than Client)**

Last Name	First Name	Date of Birth
Address		
City	State	Zip
Phone #1	Phone #2	
Relationship to Client		

**III. Insurance Information**

Insurance Carrier	Employer	
Identification Number	Group Number	Plan Code

*I understand that the insurance, as listed above, is the health contract under which I am covered. I am aware that if the above is not true or the insurance denies service/payment coverage in part or in full, I agree to pay in full all charges incurred with SUNNY M. MUELLER, LPCC to SUNNY M. MUELLER, LPCC.*

Client (PRINT)

Client (SIGNATURE)

DATE