

Insurance Authorization – ADULT

I. Client

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

II. Primary Insurance Subscriber (If different than Client)

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

III. Primary Insurance Information

Insurance Carrier	Employer	
Identification Number	Group Number	Plan Code

IV. Secondary Insurance Information

Insurance Carrier	Employer	
Identification Number	Group Number	Plan Code
Subscriber: Last Name	First Name	Date of Birth

I attest that the insurance/s listed above is/are the health contract/s under which I am covered. I am aware that if the above is not accurate, true, or the insurance/s fail to cover payment for services rendered, in part or in full, I am responsible for and agree to pay in full all charges incurred with SUNNY M. MUELLER, LPCC to SUNNY M. MUELLER, LPCC.

Client (PRINT)

Client (Signature)

Date