COUNSELING CENTER OF NORTH TEXAS

303 S. Highway 78 Suite 100 Wylie, TX 75098
720 E. Park Blvd. Suite 204 Plano, TX 75094
Phone: 469-342-3468 Fax: 469-342-3466

Secondary Insurance

Insurance Information

Insurance Company: _____

Insurance Phone: _____

Policy/ID #: _____ Group #: _____

Coverage Start Date: _____

Deductible: $_____ Amount Met: $_____ Co-pay/Co-Insurance: $_____/_____%

EAP #: _____ # of approved sessions: ___ Date Span of Approval: _____ to _____

Subscriber Information

Insured's Name: _____

Complete the following if this information was not provided above.

Relationship to Insured: _____ Insured's DOB: _____

Insured's Address (if different):_____

Insured's Phone Number: _____ Employer: _____

I hereby give the office Counseling Center of North Texas and their staff permission to file any claims and exchange any PHI (Protected Health Information) necessary to receive payment for services performed. I understand that balances unpaid after 60 days will be my responsibility. If coverage is under another individual's policy, I understand that this person may be notified of services performed.

_____ _____

Client/Legal Representative Signature Date

Client Name: _____ Date of Birth: _____