PCD Counseling
spiritually sensitive — clinically informed

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INSURANCE INFORMATION

Insurance_____ EAP _____

Client: _____ Client DOB: _____

Street Address: _____

City: _____ Zip:_____

Client Phone # _____Social Security#: _____

Relationship to Insured:_____

Employer of Insured:_____

Insured:_____ Insured DOB: _____

Street Address: _____

City: _____ Zip:_____

Client Phone # _____Social Security#: _____

Emploer of Insured:_____

Carrier: _____

Address:_____ City:_____ Zip:_____

ID#_____ Group/Policy #_____

I authorize release of any medical or other information necessary to process this claim to have my above-named insurance company. I also authorize payment of medical benefits from the above-named insurance company to PCD or the supplier for services rendered.

_____

Signature Date

FOR OFFICE USE ONLY:
Diagnosis:

Supervisor: