Gage Counseling & Consulting, LLC
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Insurance Information Form

Client Information

Name: ____

Address: ____

City: ______________________ State ________ Zip: ____________

Phone: May we identify ourselves when we call? Yes/No {Circle One}

Day: ______________ Evening: ______________ Cell: ______________

Date of Birth: ______________ SS# ______________________

Insurance Information

Primary Insurance Name ____________________________________

Policy Holder Name ____

Policy/Member ID# ______________________ Group# ______________

Relationship to Insurance Holder ______________ Date of Birth ____________
(Self, Spouse, Child, Other) of Insurance Holder

Secondary Insurance Name __________________________________

Policy Holder Name ______________________ Date of Birth __________

Policy/Member ID# ______________ Group# ______________________

I give my permission for Gage Counseling and Consulting, LLC and its authorized associates to submit all therapy sessions to my insurance company and release any medical records to the insurance as necessary. I understand that I may be responsible for any sessions my insurance doesn't cover. 24 notice is required for cancellations with the exception of an emergency situation or a fee may be charged for the missed session.

Signature ______________________________ **Date** ________________