Katherine Anderson, LPC

LICENSED PROFESSIONAL COUNSELOR

CLIENT BILLING INFORMATION FORM

Date:_____

Client:_____ **Phone#:**_____
Last First MI

SSN:_____ **DOB:**_____ **Gender: __M __F**

Address:_____ _____ _____ _____
Street/PO Box Apt# City State Zip

Responsible Party (If other than Client)

Name:_____ **DOB:**_____

Relationship to Client:_____ **SSN:**_____

Mailing Address:_____ _____ _____
Street/PO Box Apt# City State Zip

Primary Insurance

Policy Holder:_____ **DOB:**_____
Last First MI

Insurance Company:_____ **ID#:**_____

Group#:_____ **Insurance phn #:**_____

Secondary Insurance

Policy Holder:_____ **DOB:**_____
Last, First, MI

Insurance Company:_____ _____ **ID#**_____

Group#:_____ **Insurance phn #**_____ _

I understand I am responsible for all charges incurred, regardless of insurance status. I agree to pay for services as they are provided and/or pay promptly upon receipt of a statement. I acknowledge the above information is correct. I authorize my insurance company(s) to pay my therapist, _____, for services filed on my behalf. This assignment will remain in effect until revoked by me in writing.

Signature_____ Date_____