INSURANCE INFORMATION

Name of Insurance Company_____

Name of Subscriber_____

Subscriber's Date of Birth_____

Subscriber's Address _____

Subscriber's Phone #_____

Subscriber's SSN_____

Name of ***Client***_____

Client's relationship to subscriber [ ] Child [ ] Other

Client's Address_____

Client's Date of Birth _____

Group Number_____

Member Number_____

Insurance Co. Phone Number _____

Insured Employed By_____

Employer's Phone Number_____

Employer's Address_____

By signing here, you authorize Lydia Lombardi Good, LCSW, to bill and release information to your insurance company.

_____ _____ _____

Print Name *Signature* *Date*