S. Andrea Barrow, MS, LPC
Brittany Beers, MS, LPC

CLIENT INSURANCE INFORMATION

Client Name_____ Date of Birth _____
Address _____ Gender _____
_____ Marital Status _____
Phone- Home _____ Cell _____ Work _____

Insured Name _____ Date of Birth _____
Address _____ Gender _____
_____ Relation to Client _____
☐ Check if same as client address

Phone- Home _____ Cell _____ Work _____
Insurance Company _____
Insurance ID _____ Group _____
Employer _____ Authorization _____

Secondary Insurance ☐ Check if there is no secondary insurance
Insurance Company _____
Insurance ID _____ Group _____
Employer _____ Authorization _____

EAP (Employee Assistance Program) ☐ Check if there is no EAP **Company** _____
Authorization _____ Allowance _____
Employee Name _____ Employer _____

I authorize direct payment to Kissel Hill Counseling Associates, LLC for any services rendered and attest that all information is accurate and complete. I agree to pay any balance left unpaid by my insurance, and will notify Kissel Hill Counseling Associates, LLC of any changes in my insurance information immediately as they occur.

Signature of Financially Responsible Person _____ Date _____

Printed Name and Relationship _____

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