ALONG THE PATH COUNSELING SERVICES, P.C.

INSURANCE COVERAGE INFORMATION

Please complete all sections

Patient's name: _____ DOB: _____

Home Address: _____ SSN: _____

City, State, and Zip: _____ Under 18? Yes No

PRIMARY INSURANCE CARRIER INFORMATION:

Policyholder Name: _____ Gender: M F

DOB: _____ Relationship to patient: _____

Address: _____

City, State, and Zip: _____

Policyholder's Phone Number: _____

Insurance Company: _____

Insurance ID Number: _____

Group Number: _____ Employer: _____

SECONDARY INSURANCE CARRIER INFORMATION:

Policyholder Name: _____ Gender: M F

DOB: _____ Relationship to patient: _____

Address: _____

City, State, and Zip: _____

Policyholder's Phone Number: _____

Insurance Company: _____

Insurance ID Number: _____

Group Number: _____ Employer: _____

ASSIGNMENT OF BENEFITS: I hereby authorize the insurance company or companies listed above to make payment directly to the provider for the benefits herein and otherwise payable to me.

Signature(s): _____ Date: _____

(if patient is a minor, parent or legal guardian sign)

Please Copy Insurance Card(s) (both sides) Before Patient's First Session