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HEALTH INSURANCE INFORMATION

Client's Name: Client's Date of Birth:
Name of Insured: Insured's Date of Birth:

Client's Relation to Primary Subscriber: ☐ Self ☐ Spouse ☐ Child Other

Primary Insurance:

Name of insurance
(mental/behavioral health):
ID Number:
Group # (if applicable):

Address on insurance card:
City: State: Zip:
Phone Number on card:
("For provider")

Secondary Insurance:

Name of insurance
(mental/behavioral health):
ID Number:
Group # (if applicable):

Address on insurance card:
City: State: Zip:
Phone Number on card:
("For provider")

I understand that all payments and co-payments are due at time of service. I authorize release of any medical or other information necessary to process the claim. I authorize that payment from my insurance company be made on my behalf to Lisa Galliano MA, LPC-S for any services furnished to me by. This consent remains in my file and can be revoked by me at any time upon written request by me to my therapist. If my particular insurance carrier conducts random site reviews, I understand that insurance representatives may review the contents of my file. It is my responsibility to let my provider know should my insurance carrier or plan change. My signature indicates I have read and understand all of the above

Client /Guardian Signature Date