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INSURANCE INFORMATION

Name of Client____

Client's Date of Birth ____

Name of Insurance Company____________________________________

Name of Insured____

Insured's Date of Birth____

Insured's SSN_________________________Client's SSN ____________________

Group Number____

Member Number____

Insurance Co. Phone Number____________________________________

Insurance Co. Billing Address ___________________________________

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Insured Employed By____

Employer's Phone Number______________________________________

Employer's Address____

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By signing here, you authorize Heather Luevano, MFT, to bill and release information to your insurance company.

Print Name____

Signature______________________________________Date_______________