Health Insurance Information

Client's relationship to the insured: Self Spouse Child Other

Insured's Name: ___________________________________ Insured's DOB: ______________

Insured's Employer: ____

Insured's Company Address and Phone Number:

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Insurance Company Name:____

ID#:______________________________ Group #_________________________

Policy Effective Date:____

Authorization:

To enable Maleka Walters, Licensed Marriage and Family Therapist, to file insurance claims on my behalf, I certify that the information provided is correct. I authorize the following:

The release of any medical or necessary information to process insurance claims

Payment of medical benefits to Maleka Walters, Licensed Marriage and Family Therapist for care provided.

Client's Signature_____________________________________ Date:_____________________

Therapist's Signature__________________________________ Date:_____________________

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