Health Insurance Information

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

Insured's Name: _____ Insured's DOB: _____

Insured's Employer: _____

Insurance Company Name:_____

Insurance ID#:_____ Group #_____

Please include a photocopy of the front and back of the insurance card.

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:_____