INSURANCE INFORMATION AND DEMOGRAPHIC FORM

BETH KOWIESKI, MS, LCPC, CADC

Client Name:_____
DOB:_____
Billing Address:_____
_____
Marital Status: S M W D

Email Address:_____
Cell Phone:_____

Employer Name:_____ City:_____

Primary Insurance:

Insurance Carrier:_____
Identification Number:_____
Group Number:_____
Subscriber Name:_____ DOB:_____

Secondary Insurance:

Insurance Carrier:_____
Identification Number:_____
Group Number:_____
Subscriber Name:_____ DOB:_____

I give permission to Beth Kowieski, LCPC, CADC and billing staff to submit my information to my insurance company. I am aware that I am placing my signature on file for these transactions. I understand that any unpaid balances such as copays, co-insurances, deductibles and non covered services are my responsibility and will be charged to my credit card on file.