

# ALONG THE PATH COUNSELING SERVICES, P.C.

## INSURANCE COVERAGE INFORMATION

Please complete all sections

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_ Under 18? Yes No

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### PRIMARY INSURANCE CARRIER INFORMATION:

Policyholder Name: \_\_\_\_\_ Gender: M F

DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

Policyholder's Phone Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer: \_\_\_\_\_

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### SECONDARY INSURANCE CARRIER INFORMATION:

Policyholder Name: \_\_\_\_\_ Gender: M F

DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

Policyholder's Phone Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer: \_\_\_\_\_

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ASSIGNMENT OF BENEFITS: I hereby authorize the insurance company or companies listed above to make payment directly to the provider for the benefits herein and otherwise payable to me.

Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

(if patient is a minor, parent or legal guardian sign)

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Please Copy Insurance Card(s) (both sides) Before Patient's First Session