Restore Life Counseling, LLC

Client Insurance Information

Insurance Company Name:_____

Responsible Party's Name:_____

Responsible Party's SSN:_____

Responsible Party's DOB:_____

Place of Employment:_____

Relationship to client: _____

Insurance group:_____

ID#_____

Insurance phn number:_____

I certify that I have insurance coverage with the company listed above and assign directly to Restore Life Counseling Services LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially Responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____

Signature of Policy Holder Date