now & **NEXT** counseling

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Health Insurance Information

Patient's Name:_____ Patient's Date of Birth:¨_____

Insurance Company:_____ Policy Number:_____

Please fill out the following only if the patient is NOT the insurance policy holder:

Policyholder's Name: _____

Policyholder's Date of Birth:_____

Policyholder's Address:_____

Policyholder's Phone Number:_____

Policyholder's Relationship to Patient:_____

Secondary Insurance:_____

I give Now and Next Counseling permission to bill my insurance company for services rendered. I understand that I am responsible for payment of any copays or co-insurance at the time of service. I understand that I am also responsible for any fee that my insurance does not cover.

Signature:_____ Date:_____

Printed Name:_____