## **Mental Health Counseling Insurance Form**

| Client Information            |
|-------------------------------|
| Full Name                     |
|                               |
| Data of Disth                 |
| Date of Birth                 |
|                               |
| Phone Number                  |
|                               |
|                               |
| Address                       |
|                               |
|                               |
| Insurance Information         |
| Insurance Company             |
| insurance company             |
|                               |
| Policy Number                 |
|                               |
|                               |
| Group Number                  |
|                               |
| Insurance Phone               |
|                               |
|                               |
| Subscriber Name               |
|                               |
| Subscriber DOB                |
|                               |
|                               |
|                               |
| Session / Service Information |
| Date of Service               |
|                               |
| Donaidae Maria                |
| Provider Name                 |
|                               |
| Service Type                  |
|                               |
|                               |
| Diagnosis Code (ICD-10)       |
|                               |

Procedure Code

| Session Fee      |  |  |
|------------------|--|--|
|                  |  |  |
| Additional Notes |  |  |
|                  |  |  |
|                  |  |  |
|                  |  |  |
| Signature        |  |  |
| Signature        |  |  |
| Client Signature |  |  |
|                  |  |  |
| Date             |  |  |
|                  |  |  |
|                  |  |  |