Jan Slack, LMFT
5480 Baltimore Dr. Ste. 202
La Mesa, CA 91942
(619) 335-5373
(619) 464-7772 Fax

INSURANCE INFORMATION

Client Name:_____
Address:_____
Phone Number:_____
Date of Birth:_____
Social Security Number:_____
Insurance Company:_____
Group Number:_____
Policy Number:_____
Insurance Company Phone Number:_____

Name of Primary Insured:_____
Relationship to Client:_____
Address:_____
Phone Number:_____
Date of Birth:_____
Social Security Number:_____
Insurance Company:_____
Group Number:_____
Policy Number:_____
Insurance Company Phone Number:_____

Secondary Insurance Company:_____
Group Number:_____
Policy Number:_____
Insurance Company Phone Number:_____
Name of Primary Insured:_____

Amount of Copay:_____
Amount of Deductable:_____

It is the client's responsibility to obtain mental health benefits from your insurance company prior to the beginning of treatment. The client is responsible to pay all co-pays/deductibles at the beginning of each session. If the client's insurance changes at any time during treatment it is their responsibility to notify the therapist (Jan Slack, LMFT) immediately and make necessary arrangements for future billing. If for any reason the insurance company does not approve payment, the client is responsible to pay all fees in full to the therapist. Payments can be scheduled if needed.

I have read and understand the above statement.

_____ _____
Signature of Client Date