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Licensed Clinical Professional Counselor

Please fill out this form if you plan to use insurance.

Client Name: _____ Today's date: _____

EAP (Employee Assistance) Clients only:

Number of EAP sessions approved: _____

Name of EAP company: _____

Approval Number: _____

Date range approved for: _____

**If you are an EAP Client and plan to continue after your initial sessions you must also complete the insurance information listed below.

INSURANCE INFORMATION:

My Co-Insurance is: \$ _____ **Number of sessions per year:** _____

_____ **I have to meet my deductible first** **My deductible is:** \$ _____

Insurance company: _____

Insured ID #: _____ **(the client)**

Insured Policy Group: _____

Insured Employer Name: _____

Insured Plan Name: _____

Name of primary insurance holder (If different then client): _____

Primary Insurance holder's DOB: _____

Insurance Provider Phone Number: _____

(For providers to call- not the customer. Listed on your card)

I agree to pay any portion of counseling that the insurance does not cover:

Signature **Date**