STEPHANIE CRUZ-TREVINO, M.A., LPC-S **PHONE 512.705.7990**
VITALINSIGHTCOUNSELING@GMAIL.COM **WWW.VITALINSIGHTCOUNSELING.COM**

INSURANCE FORM

Circle one: BLUE CROSS TRICARE CIGNA

Are you using your Employee Assistance Program? YES NO

IDENTIFICATION #:_____ GROUP#: _____

Please fill out the form according to the information that you have on file with your insurance company.

Are you the primary on the insurance account? YES NO
If NO what is your relationship to the primary on the account? SPOUSE CHILD

Your Name as it appears on the insurance card: _____
(First) (M.I.) (Last)

DOB: _____/_____/_____

Address: _____

Primary's Name as it appears on the insurance card: _____
(First) (M.I.) (Last)

Primary's DOB: _____/_____/_____

CONSENT TO FILE CLAIMS

As a part of completing this form to obtain full or partial payment from your insurance provider, you are acknowledging that Stephanie Cruz-Trevino at Vital Insight Counseling can release the necessary information to submit claims for reimbursement of services.

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Therapist's Signature_____