

Amy C. Hampton, M.A., LPC
Insurance Information

Please give your insurance card and driver's license to the counselor so copies can be made.

Client's Name: _____

Client's Date of Birth: _____

Client's Relation to Primary Subscriber:

____ Self ____ Spouse ____ Child ____ Other

Primary Insurance Subscriber (if other than client): _____

ID Number of Primary Subscriber as listed on Insurance Card: _____

SS# of Primary Subscriber: _____

Date of Birth of Primary Subscriber: _____

Address: _____
City: _____ State: _____ Zip: _____

Home Phone Number: _____

Employer of Subscriber: _____

Insurance Company: _____

Behavioral Health Insurance Underwriter (if different from Insurance Co):

Address for Billing Behavioral Health Claims:

I authorize my insurance benefits to be paid directly to the counselor. I understand that I am financially responsible for any balance. I also authorize Amy C. Hampton, M.A., LPC, or insurance company to release any information required to process my claims.

Client/Guardian Signature

Date

Please make a copy of your **Insurance Card** (Front and Back) and
a copy of your **Driver's License** and please attach.