



Associated Counseling Group

748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
402-941-7016 ♦

INSURANCE INFORMATION
Client Relationship to insured ___Self ___Spouse ___Child ___Other:
Insured's Name(who carries the ins. policy) SS# Date of Birth (00/00/0000)
Address City State Zip Code
Home Phone # Work Phone # Cell Phone # Gender
Employer of insured or School Check one: ___PT Student ___FT Student ___Employed

INSURANCE POLICY INFORMATION- Please give your insurance card to the support staff to photocopy.
Office Insurance policy: We will file your insurance, when possible, if we are unable to determine your insurance benefits prior to your first visit, the full session fee will be charged and you will be solely responsible for that fee.

Primary Insurance Company Name Secondary Insurance Company Name
Address Address
City ST Zip City ST Zip
Benefits Phone # Benefits Phone#
Plan Name Plan Name
Identification # & SS# Identification # & SS#
Policy & Group # Policy & Group #

I hereby assign all benefits otherwise payable to me to Associated Counseling Group, as payment towards the charges incurred for services rendered. I further instruct the insurance company named above to issue a check directly to Associated Counseling Group.

SIGNED BY: DATE:

BILLING INFORMATION
If another individual or agency is responsible for payment, please complete the information below.

Billable Responsible Party Name
Responsible Party Relationship to Client Social Security #
Address City State Zip Code
Home Phone # Work Phone # Cell Phone # Gender ___M ___F Date of Birth:
Employer Percentage of Bill Responsible For: