

**Barbara Flor Counseling, LLC**  
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**Licensed Mental Health Counselor (FL)**

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**INSURANCE INFORMATION**

MANY HEALTH INSURANCE PLANS HAVE A DEDUCTIBLE THAT MUST BE MET BEFORE THE PLAN PAYS FOR VISITS. PLEASE INSURE YOUR DEDUCTIBLE HAS BEEN MET OR YOU WILL BE RESPONSIBLE FOR FULL PAYMENT OF THE VISIT.

It is up to the client to know his/her insurance coverage, including knowledge of co-payment amounts and yearly deductibles. If the claim is denied by the insurance company for any reason, it is the responsibility of the client or parent/guardian to pay the bill in full. **Copayments and deductibles are always due at the time of service. A credit card will be kept on file for visits denied by the insurance company.**

Does plan require a Pre-Authorization? NO \_\_\_ YES \_\_\_ Pre-Authorization #: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_\_

Client's Relationship to insured: \_\_\_\_\_

Client's status: Single \_\_\_\_\_ Married \_\_\_\_\_ Partnered \_\_\_\_\_ Other \_\_\_\_\_

Employed \_\_\_\_\_ Full-time student \_\_\_\_\_ Part-time student \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_

Insured's Employer or School:  
\_\_\_\_\_

PRIMARY INSURANCE COMPANY:

\_\_\_\_\_

Address (where to mail claims):

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_