

**Danielle Adler Witchel, LCSW**  
**Insurance Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Family Physician: \_\_\_\_\_

In case of Emergency Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize the release of any clinical information or other information necessary to process my insurance claim: (circle) Yes / No

I authorize payment of insurance benefits to the above listed provider. (circle) Yes / No

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Soc. Sec. # \_\_\_\_\_

Policy Holder's ID#: \_\_\_\_\_ Policy Holder's Group #: \_\_\_\_\_

Policy Holder's Birthdate: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone Number: \_\_\_\_\_

Policy Holder's Current Address: \_\_\_\_\_

Is Policy Holder (circle) Male / Female

Policy Holder's Marital Status: \_\_\_\_\_ Relationship to client? \_\_\_\_\_

Insurance Company phone # for claims: \_\_\_\_\_ For Benefits: \_\_\_\_\_

Insurance Company Billing Address: \_\_\_\_\_

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

I ALSO NEED A COPY OF YOUR INSURANCE CARD IN ORDER TO PROCESS  
CLAIM