



INTERFACE-SAMARITAN COUNSELING CENTERS (ISCC)

PAYMENT INFORMATION

Client Name _____ ISCC FILE # _____

Guarantor/Person Responsible for Payment _____

Date of Birth _____ Relationship to Client _____

Address _____ Home Phone _____ OK to Leave Message? Y N
(if different from client)

City/Zip _____ Cell Phone _____ OK to Leave Message? Y N

E-mail: _____ Work Phone _____ OK to Leave Message? Y N
OK to send message? Y N

INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____

Relationship to Client _____

Name of Medical Insurance Co. _____

Insurance Mailing Address _____

City/Zip _____ Insurance Phone _____

Group # _____ Policy # _____ ID# _____

Is Pre-authorization required? Y N Authorization Code _____

Start Date of Authorization _____ EAP? Y N

End Date of Authorization _____ Total # Sessions Authorized _____

Secondary Insurance (if applicable) _____ Insurance Phone _____

Insured's Name _____ DOB _____ Relationship to Client _____

Group # _____ Policy # _____ ID# _____

