MAGNOLIA ROOTS
Counseling

# Patient Insurance Form

## Patient Information

Full Name: _____ Date of Birth: _____

Gender: □ Male □ Female □ Other

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

## Insurance Information

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Insurance Phone Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Policyholder: _____

## Acknowledgment and Signature

I hereby authorize the release of any medical information necessary to process my insurance claims. I understand that I am financially responsible for any balance not covered by my insurance.

Signature: _____

Date: _____

## Instructions

Fill out all sections completely and return to Magnolia Roots Counseling.

Email: therapywtori@gmail.com or Fax: 512-842-7238

Submit the form before your appointment.