

Family Counseling Connection

1021 Quarrier Street, Ste 414

Charleston, WV 25301

(304) 340-3676

I authorize the release of any medical or other information necessary to process claims for services rendered and billed to my insurance company. I also authorize payment of medical benefits to Family Counseling Connection.

Client's Name: _____ Date of Birth: _____ (male) or (female)

Relationship to Insured: (self) (spouse) (child) (other)

Primary Insured's I.D. Number: _____

Member's name: _____

Insured's Address: _____

Insured's Policy Group: _____ Insured's Date of Birth: _____

Employer: _____

Is there another health benefit plan? (Yes) (No)

Secondary Insured's I.D. Number: _____

Relationship to Insured: (self) (spouse) (child) (other)

Member's name: _____

Insured's Address: _____

Insured's Policy Group: _____ Insured's Date of Birth: _____

Employer: _____

Client Signature: _____ Date: _____

Insured's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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