*Steve P. Swartz, LISW*
*Individual, Marriage, and*
*Family Counseling*

## Insurance/Payment Information

**Primary Insurance Co.** _____ Date of Birth _____

Insured Name _____Rel. to Client _____

Address _____Phone ____ _____ _____

Policy# _____ Group# _____

Employer _____ Authorization# _____

Client Name_____ Date of Birth _____

Client Address _____Employer/School _____

**Secondary Insurance Co.** _____

Insured Name _____

Address_____

Policy# _____ Group# _____

Employer _____

I (we) authorize payment of mental health benefits to the provider herein for all counseling services rendered. I (we) authorize the provider to release any information required to process my insurance claims. I (we) authorize my insurance benefits to be paid directly to Steve Swartz, LISW. I (we) understand that I (we) are financially responsible for payment of any insurance deductible, co-payments, and non-covered charges or services. A photocopy of this signature is as valid as the original.

Signature of Responsible Party _____ Date _____

Please notify us of any changes to your insurance.

121 N. Main St.
London, Ohio 43140

740-506-1306 (also text)
740-852-3338 (fax/recorder)

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