Adult Intake Form Insurance Release

Community Care and Counseling of Aiken

Date:_____

Insured Name:_____

SS#_____

DOB:_____

Client Name:_____

DOB:_____

SS#_____

Relationship to Insured:
___ Self
___ Spouse
___ Child
___ Other

Insurance Agency:_____

Group #_____

I hereby authorize Community Care and Counseling of Aiken to release the information necessary to process payment of my insurance claim and to receive reimbursement from my insurance policy.

_____ _____
Client Signature Date Witness Signature

_____ _____
Signature: Parent or Legal Guardian Date Relationship