Fresh Perspectives Counseling
2111 Dickson Drive, Suite 22
Austin, TX 78704
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INSURANCE INFORMATION

Full Name (as it appears on insurance card): ___________________________________

Insurance Provider: ____

Policy/ID Number: ____

Group Number: ____

Provider Phone Number: (on back of card) _____________________________________

Mental Health (MH) Phone Number: (on back of card) _________________________

Do you know if you have a co-pay? If yes, how much? _________________________

Do you know if you have a deductible? If yes, how much? ______________________

Are you the policy holder?

If **YES**, you do not have to complete the rest of the form.

If **NO**, name of policy holder: ____

Birthdate of policy holder: ____

Address of policy holder (If different from yours):

____

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Phone number of policy holder: ____