Insurance Information and Release

Insurance Company _____

Policy Holder's Name _____

Policy Holder's Date of Birth _____

Policy Holder's Address:

Street_____

City _____ State _____ Zip _____

Policy Holder's Employer _____

Group ID# _____ CoPay $ _____

Member ID# _____ Deductible $ _____

Claims Address _____

Customer Service Phone # _____

Authorization Number (if required) _____

Insurance Assignment/Release & Agreement

I _____, hereby authorize my insurance benefits to be paid directly to Lisa Haake, Ph.D., LMFT, and I understand that I am financially responsible for non-covered services. I also authorize Lisa Haake, Ph.D., LMFT to release any information required to process the insurance claims. If I miss or cancel my appointment without 24 hour's notice, I understand that I will be billed the entire fee for the session.

Client Signature _____ Date _____