Transitions
Counseling and Consulting

19420 North 59th Avenue, Suite B-247
Glendale, AZ 85308
(602) 363-0629

Insurance Information

Name: _____ Date of Birth_____

Address:_____Phone:_____

Insurance Company: _____ Plan Name: _____

Name of the Insured Person: _____ Relationship: _____

Employer: _____ Insured's Date of Birth _____

Insurance ID Number: _____ Group Number: _____

Acknowledgement:

- It is your responsibility to verify your insurance benefits and eligibility.
- By signing below I acknowledge that I am responsible for any expenses not covered by insurance.

Printed Name: _____ Signature: _____ Date: _____

**To be completed by office staff**

☐ In Network ☐ Out of Network Effective Date _____

Deductible _____ How much has been met _____

Out of pocket Maximum _____ Copay _____

Co-Insurance _____ Authorization Required _____

Session Maximum _____ Other Information _____

_____

Date Benefits Verified _____ By _____