SERENITY & HOPE, LLC
Kathleen Hurley, Med, LPC, NCC
140 Prospect Ave Suite O
Kirkwood, MO 63122
Katie.hurleylpc@gmail.com
314-690-1667

Insurance Information

CLIENT NAME_____ DOB: _____

ADDRESS: _____

CITY: _____ STATE_____ ZIP CODE:_____PHONE: _____

SUBSCRIBERS INFORMATION:

PRIMARY INSURANCE CARD HOLDER NAME: _____ DOB:_____

ADDRESS OF PRIMARY (IF DIFFERENT THAN CLIENT) _____

CITY: _____ STATE:_____ZIPCODE:_____ PHONE: _____

PRIMARY INSURANCE COMPANY: _____

ID # _____ GROUP # _____

PLEASE NOTE:
I, THE INSURANCE HOLDER, AM RESPONSIBLE FOR CALLING MY INSURANCE AND VERIFYING IF REFERRAL IS NEEDED, MY DEDUCTIBLE AMOUNT, CO-PAY, AND NUMBER OF SESSIONS ALLOWED PER YEAR. I UNDERSTAND THAT IF MY INSURANCE COMPANY DOES NOT PAY, I WILL BE RESPONSIBLE FOR MISSED SESSIONS.

_____

SIGNATURE **DATE**

_____

KATHLEEN HURLEY **DATE**

◯ _____Copy of Insurance card has been provided to therapist.