INSURANCE INFORMATION Please complete all information requested

PRIMARY INSURANCE:ADDRESS:		SECONDARY:	
		ADDRESS:	
TEL	EPHONE:	TELEPHONE:	
GROUP #:		GROUP#	
INSURED'S NAME:		INSURED'S NAME:	
POLICY#:		POLICY#:	
INSURED'S D.O.B.:		INSURED'S D.O.B.:	
POLICY EFFECTIVE DATE:		POLICY EFFECTIVE DATE:	
 I hereby authorize Triss Fifer, LCSW, to: Furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested. 			
2)	including records if requested.		
_,	from time to time relating to my care.		
I acknowledge that I am responsible for all charges not covered by my insurance. I understand that any money received from me by Triss Fifer, LCSW, in excess of my bill will be refunded to me after completion of treatment. I also understand that I will be charged for any appointment that I fail to keep or cancel within 24 hours prior to that appointment time and I agree to pay those charges in full.			
(If	tient's signature Date for a minor, parent or legal uardian's signature.)	Responsible party's signature	