Pediatric Counseling Center

375 Collins Road NE, Suite 17 Cedar Rapids, Iowa 52402

Angela Cantrell Fielding Counseling, LLC **319-208-0175**

Dr. Sandra K. Fischer Counseling, PLLC **319-409-6899**

Insurance Information

Client Name:_____ DOB:_____

Primary Insurance:

Insurance Company:_____

Subscriber ID#:_____Group ID#:_____

Subscriber Relationship to Client: ☐ Father ☐ Mother ☐ Self ☐ Other_____

Subscriber Information

Name:_____DOB:_____

Address:_____Phone #:_____

Employer Name:_____

Secondary Insurance

Insurance Company:_____

Subscriber ID#:_____Group ID#:_____

Subscriber Relationship to Client: ☐ Father ☐ Mother ☐ Self ☐ Other_____

Subscriber Information

Name:_____DOB:_____

Address:_____Phone #:_____

Employer Name:_____

Assignments of Benefits:

I agree to guarantee payment of charges incurred for services rendered at Pediatric Counseling Center (Angela Cantrell Fielding Counseling, LLC; Dr. Sandra K. Fischer Counseling, PLLC). I hereby authorize payment of insurance benefits otherwise due or payable to me on my behalf to Pediatric Counseling Center (Angela Cantrell Fielding Counseling, LLC; Dr. Sandra K. Fischer Counseling, PLLC). I understand that I am responsible for, and agree to pay, all charges not covered by insurance including any applicable copays, coinsurances, or deductibles.

_____ _____

Signature of Responsible Party Date

_____ _____

Printed Name of Responsible Party Relationship to Client