MEDICAL INSURANCE CARD ON FILE

Client name: _____

☐ I certify that I have medical insurance and have confirmed that services rendered by New Milford Counseling Center are covered. I understand that if my insurance is not effective on the date of service I will be responsible for the full cost of service.

Medical Insurance Information: _____

Provider: _____

ID#/Group#: _____

Effective Date: _____

☐ I certify that I DO NOT have medical insurance or DO NOT wish to utilized my insurance plan for coverage of services provided by New Milford Counseling Center. I agree to pay the following amount for said services

Initial Assessment: $200

Follow up Sessions: $175 for 60 minutes, $150 for 45 minutes

Client Signature: _____

Date: _____