ANTHONY HAMPTON LISW-CP

Addictions Counseling | Therapy | Yoga

Insurance Authorization Form

Name _____ / _____ / _____
Last First MI

Address _____ / _____
Street City

_____ / _____
State Zip Code

DOB ____ / ____ / ____
MM DD YYYY

SSN _____

Member ID Number _____

Rx Bin Number _____

Group _____

Plan Code _____

*** Co-payments are due at time of service**

Policy-holder is solely responsible for provider's full fee in the event of a cancellation less than 24 hours prior to scheduled appointment