Rachel Mathew, LCSW
Turning Point Psychotherapy, PLLC
6845 Fairview Road, Charlotte 28210

INSURANCE INFORMATION

Name _____ Date of Birth _____

Name of Insurance _____

Policy Number _____ Group # _____

Name of Primary Policy Holder _____ Date of Birth _____

Relationship of Policy Holder to you _____

Address of Primary Policy Holder, if different to yours _____

_____

I hereby voluntarily and knowingly consent to allow Rachel Mathew, LCSW to use and /or disclose my health information as deemed appropriate to carry out treatment, payment, and /or healthcare operations of the practice. For substance abuse information, payment information can only by obtained by those for whom an authorization exists.

_____ _____
Signature of Client (Representative) Date