Recovery Counseling Center, LLC
7211 Park Heights Avenue, Suite 4
Baltimore, Maryland 21208 443-681-9150
Fax: 1-877-715-7229 Email: office@rccbaltimore.com

INSURANCE/DEMOGRAPHICS

Client's name (first and last): ____

Address:_______________________ Apt:__ City:_________ State:___ Zip: ________

Phone: ____________________ email: ____

May we leave confidential voicemail? ___Yes/ No_____

DOB:____/_____/________ Sex: M / F Referred by: __________________________

Insurance provider: ______________________________ Out-of-state? ________

Member ID: _________________________ Group number: ____________________

Medical Assistance No. (11 digits) _______________________________________

Please provide us with your actual insurance card and state ID so we can photocopy the front and back for our records.

I certify that the information provided is true to the best of my knowledge. I understand that it is my responsibility to inform the company regarding any changes in my insurance, coverage or demographics. I grant permission for RCC staff to contact my insurance provider to determine my benefits and to bill me for all services rendered. I understand that anything not covered by my insurance, including but not limited to required copays, deductibles, rejected claims or use of service without an authorization in place, will be billed directly to me. I agree to pay all copays at the time of service and I understand that all deductibles and fees are my responsibility. Canceled or bounced (bad) checks have a $35 fee and payment must be made up before the next session.

Signature: ____ Date: ______________