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 and me for all services rendered. I understand that anything not covered by my insurance including if I close the authorization and continue to attend sessions 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 checks have a $35 fee and payment must be made up before the next session.

Signature: _____ Date: _____