Daniel J. Lebsack MA, LPC
Private Mental Health Practitioner
700 Valley View Drive
Woodland Park, CO 80863
Ph: 719-290-4393
centralcoloradocounseling@gmail.com
www.centralcoloradocounseling.com

Patient Name:	Age:	Date of Birth:	SS#:

Home Address: _____City_____State_____Zip_____

Name of Insured _____ Insured's SS# (aka, Sponsor's SS#)_____

Insured's I.D. #_____ Insured's Date of Birth _____

Health Insurance Co _____

CoPay Amount $_____ Deductible Amount $_____

Insured's Policy Group # _____

Authorization ID # (If Tricare or EAP) _____ # of sessions authorized: _____

Is there another Health Benefit Plan? Yes ____ No ____

(please provide Ins. Policy Name & ID and Group) #_____

I authorize payment of medical benefits from my insurance plan to Daniel Lebsack MA, LPC for psychotherapy services rendered. I accept responsibility for making the appropriate co-payments.

Also, I authorize the release of any medical or other information necessary to process insurance claims. In the event that Daniel Lebsack MA, LPC is not reimbursed by my insurance company for services rendered, I accept responsibility for payment of psychotherapy charges.

Signed: _____

Date of Insurance Information Update: _____