Psychological & Counseling Centre, LLC

1201 South Main St., Suite 100
North Canton, Ohio 44720
330 244-8782
fax 330 244-8795
www.vistapcc.com

PAYMENT OPTIONS (Please check one):

___ Insurance

___ Self – Pay

___ EAP

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Patient: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ □Male □Female

Social Security Number of Insured: _____

Place of Employment of Insured: _____

Address of Employer: _____

Phone Number of Employer: _____

Name of Insurance Company: _____

Address of Insurance Company (to submit claims):_____

City/State/Zip: _____

Phone Number of Insurance Company: _____

Policy Number: _____ Group Number: _____

Effective Date: _____ Co-payment, if known: _____

***If there is secondary insurance in place, please complete back of this page.**

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SECONDARY INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Patient: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ ☐Male ☐Female

Social Security Number of Insured: _____

Place of Employment of Insured: _____

Address of Employer: _____

Phone Number of Employer: _____

Name of Insurance Company: _____

Address of Insurance Company (to submit claims):_____

City/State/Zip: _____

Phone Number of Insurance Company: _____

Policy Number: _____ Group Number: _____

Effective Date: _____ Co-payment, if known: _____