



Ensemble Therapy

Jaclyn Sepp, MA, LPC, RPT, NCC  
2520 Longview Street, Suite 212  
Austin, Texas 78705  
512.762.4030

## INSURANCE POLICY

Required:

1. A photocopy of your Drivers License
2. A photocopy of your Insurance Card
3. This complete form with signature

Name of Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

Member ID: \_\_\_\_\_

Plan ID: \_\_\_\_\_

Group ID: \_\_\_\_\_

Co-Pay: \_\_\_\_\_

Deductible: \_\_\_\_\_

Employer/School: \_\_\_\_\_

I/we authorize Jaclyn Sepp, MA, LPC, RPT, NCC to submit a claim to our insurance company for therapy sessions. I understand that if the bill is unpaid in 45 days I am responsible for the remaining balance. I also understand the cancellation policy for appointments and I am responsible for the **full session fee** if cancellation occurs after the 24 hour window.

\_\_\_\_\_  
Client name

\_\_\_\_\_  
Date