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CLIENT INSURANCE FORM

Please complete the following if you will be using insurance for your psychotherapy sessions.

Primary Insurance Information

Insurance Company: _____

Identification #: _____ Group #: _____

Provider Services Phone #: _____

Insurance Company Address (on back of card): _____

Policy Holder Name: (if different then client) _____ DOB: _____

Social Security #: _____ Employer: _____

Relationship to Client: _____ Phone Number: _____

Mental Health Plan (if different): _____

Identification #: _____ Group #: _____

Provider Services Phone # (on back of card): _____

Insurance Company Address (on back of card): _____

Secondary Insurance Information

Insurance Company: _____

Identification #: _____ Group #: _____

Provider Services Phone #: _____

Policy Holder Name: (if different then client) _____ DOB: _____

Social Security #: _____ Employer: _____

Relationship to Client: _____ Phone Number: _____