Danielle Roginski, LCSW
420 South State Road 7, Suite 118
Wellington, FL 33414
(561) 779-6711

INSURANCE AUTHORIZATION

Client Name: _____ Date of Birth: _____

Relationship to Insured: _____

Insured's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Insurance Company: _____

Insurance ID Number: _____

Plan Name: _____ Group Number: _____

I hereby authorize the payment of benefits by my insurance company to Danielle Roginski, LCSW for services covered by my policy. I further authorize the release of any medical or other information necessary to process this claim.

_____ _____
Signature Date

_____ _____
Signature Date