G. Scott Jakovics, MA-CAGS, LCPC, LCADC
Professional Counseling Services

410-279-3174

Insurance Information

The following form must be completed prior to first appointment or I will have to charge my full private fee.

Client name:__________________________ Client's Date of Birth:_________________

Insured's name:______________________ Insured's Date of Birth:________________

Name of Insurance Company:____________________ Phone Number:________________

Insurance Identification Number:______________________

Group Identification Number:_________________________

Referral Necessary? Yes___ No ____

Authorization Number:_______________________________

Number of sessions authorized? _______________________

Amount of deductible?________________________________

Copay or Coinsurance amount per visit? _____________________

Calendar limit for sessions? ________________________________

Is a treatment plan necessary?________ If yes, when is it needed? _________________

It is the client's responsibility to ensure that authorizations and referrals are obtained and that this sheet is completed prior to the initial visit. The following information will be helpful for the insurance company in identifying me as an in-network provider:

George Scott Jakovics (I go by my middle name Scott but some companies have me under George)
Professional Counseling Services (It is unusual but some companies have my business name)
Tax ID #: 52-2281913

I understand that the initial authorization and referral process is my responsibility and until the insurance companies approve my visits, I am responsible for full private fee which is explained on the "Disclosure Statement" included in this packet:

______________________________________ _________________________
Clients signature Date