

Family Service: Prevention, Education, & Counseling

Insurance Information Form

- Do you have insurance? No
- Primary Insurance: Medicare Private
- Secondary Insurance: Yes
- Insured Relationship to Client: Self Spouse Parent
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Client Information	Insured Information
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<i>Name</i>		<i>Name</i>	
<i>Address</i>		<i>Address</i>	
<i>City</i>		<i>City</i>	
<i>State</i>		<i>State</i>	
<i>Zip Code</i>		<i>Zip Code</i>	
<i>Phone Number</i>		<i>Phone Number</i>	
<i>Date of Birth</i>		<i>Date of Birth</i>	

Primary Insurance	Secondary Insurance
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<i>Insurance Name</i>		<i>Insurance Name</i>	
<i>Insurance Address</i>		<i>Insurance Address</i>	
<i>Insurance City, St, and Zip</i>		<i>Insurance City, St, and Zip</i>	
<i>Phone</i>		<i>Phone</i>	
<i>Group Number</i>		<i>Group Number</i>	
<i>Policy Number</i>		<i>Policy Number</i>	
<i>Employer's Name</i>		<i>Employer's Name</i>	

Patient or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment.

Insured's or Authorized Person's Signature:

I authorize payment of medical benefits to the undersigned provider of mental health services.

Client's Acknowledgement of Responsibility for Payment for Services:

I understand that I am responsible for payment for services rendered to me regardless of whether I am reimbursed for these services by my insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I have obtained preauthorization from my insurance company if it is a requirement to receive benefits.

PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT OR INCLUDE A PHOTO COPY OF YOUR CARD WITH THIS FORM.

To be filled out by Therapist: *(Please leave blank.)*

Therapist Name:

Case Number:

Diagnosis Code:

Case Number: