revive
Clinical Counseling

INSURANCE INFORMATION

CLIENT INFORMATION

Client's Name:_____ DOB:_____ SSN____-_____-_____
Insured's Name:_____ DOB:_____ SSN ____-_____-_____
Insured's Address:_____
(Insured is the person who carries the insurance. If insured person is the same as patient, you may write "SAME").
Health Insurance Provider:_____ Phone:_____
Policy # _____ Group/Plan #_____
Do you have a deductible? __Yes __No Amount of deductible $_____
Has deductible been met? __Yes __No If no, how much of deductible has been met? $_____
Do you have a co-payment? __Yes __No Amount of your co-payment: $_____
Authorization Number: s_____

ASSIGNMENT of BENEFITS

I hereby authorize payment directly to Whitney Schlife, LPCC, of the benefits otherwise payable to me under the terms and conditions of my health insurance. I understand that I am financially responsible to the above provider for the charges not covered by my insurance. I understand and agree that all accounts are due and payable at the time of service and that insurance is being billed as a courtesy. In insurance assigned cases, Whitney Schlife, LPCC agrees to accept the charge determination of the insurance carrier as the full charge and I am only responsible for the deductible, co-payment, and non-covered services. If my insurance carrier denies payment for these services, I agree to be personally responsible for the payment.

_____ _____

Client's Name (Printed)

Parent/Guardian's Name and relationship to Minor Client (Printed)

_____ _____

Client or Parent/Guardian's Signature

Date

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process insurance claims or obtain additional/continued authorization for services. I understand that this release includes billing and clerical personnel who are also under legal obligation to maintain confidentiality.

_____ _____

Client's Name (Printed)

Parent/Guardian's Name and relationship to Minor Client (Printed)

_____ _____

Client or Parent/Guardia's Signature

Date