INSURANCE INFORMATION

You are responsible for confirming and obtaining authorization for health care benefits available to you. We are Licensed Clinical Social Workers, Marriage and Family Therapists, or Licensed Clinical Psychologists, depending upon your therapist; Board Certified in Mental Health for practicing counseling and psychotherapy. You are responsible for any charges such as deductibles and co-pays not covered by your health care plan or denied for any reason, for any interest charged and for late cancellation or no show charges. Interest of 1.5% per month (18% APR) is charged on balances due over 60 days.

CLIENT INFORMATION

Thank you for providing complete, accurate and legible information

CLIENT NAME:_____ ☐**FEMALE** ☐**MALE (gender on insurance)**

CLIENT ADDRESS:_____

CLIENT DATE OF BIRTH _____ **CLIENT SSN:** _____

CLIENT RELATIONSHIP STATUS: ☐**SINGLE** ☐**MARRIED** ☐**DATING** ☐**PARTNERED**

CLIENT RELATION TO SUBSCRIBER: ☐**SELF** ☐**SPOUSE** ☐ **CHILD** ☐**OTHER**_____

COVERAGE START DATE: _____ **COVERAGE END DATE:** _____

PRIMARY INSURANCE INFORMATION ☐**N/A**

SUBSCRIBER INFORMATION ☐ **Same as Above**

SUBSCRIBER NAME: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DATE OF BIRTH _____ ☐**FEMALE** ☐**MALE (gender on insurance)**

NAME OF HEALTH CARE PLAN: _____

CLAIM ADDRESS (on back of card)_____

CLAIMS PHONE NUMBER _____ **CLAIMS FAX NUMBER**_____

SUBSCRIBER ID# _____***GROUP#***_____

DEDUCTIBLE AMOUNT: _____ **CO-PAY AMOUNT:**_____

AUTHORIZATION NUMBER IF REQUIRED: _____

COVERAGE START DATE: _____ **COVERAGE END DATE:** _____

SECONDARY INSURANCE INFORMATION ☐ **N/A**

SUBSCRIBER INFORMATION ☐ **Same as Above**

SUBSCRIBER NAME: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DATE OF BIRTH _____ ☐ **FEMALE** ☐ **MALE (gender on insurance)**

NAME OF HEALTH CARE PLAN: _____

CLAIM ADDRESS (on back of card)_____

CLAIMS PHONE NUMBER _____ **CLAIMS FAX NUMBER**_____

SUBSCRIBER ID# _____***GROUP#***_____

DEDUCTIBLE AMOUNT: _____ **CO-PAY AMOUNT:**_____

AUTHORIZATION NUMBER IF REQUIRED: _____

COVERAGE START DATE: _____ **COVERAGE END DATE:** _____

TERTIARY INSURANCE INFORMATION ☐ **N/A**

SUBSCRIBER INFORMATION ☐ **Same as Above**

SUBSCRIBER NAME: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER DATE OF BIRTH _____ ☐ **FEMALE** ☐ **MALE (gender on insurance)**

NAME OF HEALTH CARE PLAN: _____

CLAIM ADDRESS (on back of card)_____

CLAIMS PHONE NUMBER _____ **CLAIMS FAX NUMBER**_____

SUBSCRIBER ID# _____***GROUP#***_____

DEDUCTIBLE AMOUNT: _____ **CO-PAY AMOUNT:**_____

AUTHORIZATION NUMBER IF REQUIRED: _____

COVERAGE START DATE: _____ **COVERAGE END DATE:** _____

Your signature indicates agreement with the above terms, authorizes Center for Family & Maternal Wellness to furnish information necessary to process your claims, to receive information about your medical history and assigns benefits for payment directly to us.

_____

Signature Date