**Wellness Counseling**

*Main Office*
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# Client Insurance Form

Patient: _____ DOB: _____

Date: _____

## Insurance Policies

_____**I do not have or do not want to use insurance benefits**. I will be responsible for all charges related to the services rendered.

### Primary Policy Information

Insurance Company: _____

Member/Beneficiary ID: _____

Policy Group:_____

Policy Holder Name/ Relationship:_____

### Secondary Policy Information

Insurance Company: _____

Member/Beneficiary ID: _____

Policy Group: _____

Policy Holder Name/ Relationship: _____

## Release of Information & Assignment of Benefits

I understand and agree to the following:

- I authorize the release of information from my medical record to the insurance company or other third-party payer named above. This information shall include all information necessary to submit and process claims, such as my name, date of birth, address, medical diagnosis, and services provided to me.
- If the practice has already shared information with the insurance company or other third-party payer at the time I revoke this authorization, it is too late to prevent that information from being shared.
- This authorization is necessary for the practice to determine eligibility for treatments or benefits or to pay for treatments I receive, but the practice cannot condition treatment on the provision of this authorization.
- This authorization shall be effective for 1 year from the date of my signature, unless I contact the practice in writing any time prior to then to revoke.
- If you are using Medicare benefits, you also agree to the following: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

In consideration of the services provided to me, I assign all benefits to the practice, if accepted, and authorize this insurance company to make payments directly to the practice and its affiliates on my behalf.

## Acknowledgment

I have read and understood the contents of this form. All information entered by me is true and accurate, and I have only entered information about myself or an individual I am authorized to act on behalf of, such as my child. I consent to use electronic signatures, and my signature below is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Printed Name:_____

Signature:_____

Date:_____