Insurance Form

This Document is Confidential

Today's Date: ______/_______/_______

Client Name: ____

Name of Insurance Holder: ____-_______________________________________

Card holder's Address: ____ City: ____________________________

State: __________________ Zip: ____

Phone: ____ Date of Birth:_____/_____/______ Gender: M / F

Insurance Information

Insurance Company (Priority Health or Blue Cross Blue Shield): ____

Number/ID (with letters):____

Group number: ____ Co-Pay Amount: $____

By signing below you agree to the following:

You do not have or use Medicaid or Medicare as your primary or secondary form of insurance (Exception: Priority Health Medicaid). If your insurance does not reimburse for mental health appointments, *you are responsible to pay the full insurance contracted rate.* We require co-pay at the time of services. If your insurance provider is one that Hope Heals Counseling, LLC does not accept, we can provide (upon written request) coded insurance receipts that clients may submit to their respective insurance company for potential reimbursement. You will be charged at the regular hourly rate for this service. In order to bill your insurance (if you are using this benefit), we are required to disclose certain information to your insurance company. You authorize Hope Heals Counseling, LLC to release the necessary information for transactions and assignment of benefits for claims.

Client Signature: ____

Date: ______________________________