SAMARITAN counseling center

Insurance Information

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST OR THERAPIST

Name of Client:				
Is client covered by insurance? ❑ **Yes** ❑ **No**		**Is pre-authorization for mental health benefits required?** ❑ **Yes** ❑ **No**		
1. Primary Subscriber's Name:	Birth date: / /	Address (if different):	Home Phone: ( )	
Name of Primary Insurance:	Subscriber's S.S.N.:	Policy #:	Group #:	Co –payment: $
Is this person a client here? ❑ Yes ❑ No				
Occupation:	Employer Name and Address:		Employer Phone: ( )	
Client's Relationship to Subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	
2. Secondary Subscriber's Name:	Birth Date / /	Address (if different):	Home Phone: ( )	
Name of Secondary Insurance	Subscriber's S.S.N.:	Policy #:	Group #:	Co-payment: $
Occupation:	Employer Name and Address		Employer Phone:	
Client's Relationship to Subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	

SIGNATURE AND CONSENT

I agree to the policies of Samaritan Family Health & Counseling Center described in the Counseling and Fee Agreement. I understand that I am responsible to obtain pre-authorization when my insurance company requires it. I hereby authorize the release of all information with respect to myself or the client named above which may be requested by my insurance company in order for them to determine coverage. I certify that the above information in support of this claim is true and correct. My insurance benefits will be paid directly to the Center. I understand that my policy is a contract between myself and my insurance company. Charges incurred are my responsibility. I understand that I am responsible for charges that are not reimbursed by my insurance company.

I authorize payment of medical benefits to Samaritan Counseling Center for services described.

Client (Guardian) Signature_____Date:_____

We are here to help.