PERSONAL INFORMATION
AND INSURANCE FORM

Client's Name (include middle initial): _____ DOB: _____ Sex: _____

Home #: _____ Cell #: _____ Work #: _____ (Accept calls at work? Yes /No)

Email Address: _____ Best way to contact you: _____

Home Address: _____

Occupati_____ Employer: _____ How long: _____

Yo_____eking counseling: _____

In_____of emergency con_____Phone_____

Wo_____like to rece_____c informat_____ailings? Yes/No

_____nce Inform

_____nsured's_____e: _____ Ins_____OB: _____

_____iplo_____

_____ient_____nsuran_____arri_____

Policy numb_____nsur_____D_____ber: _____

Group ID Nu_____er: _____ranc_____m_____pho_____umber_____

Insurance company's addres_____

Is there another mental health_____nefi_____an? _____

Mental Health Benefit (questio_____ask y_____nsurance comp_____

1. Is Licensed Mental Health Counselor (LPC) in Florida on the a_____ved list of provid_____
2. Out patient counseling coverage: _____
3. Percent coverage: _____ Deductible: _____ How much has b_____et? _____
4. Is precertification required? _____
5. Maximum payable per year: _____ Max visits/year? _____ Max visits/w_____
6. Person Contacted: _____
7. Address for filing claims: _____
8. In network coverage_____ Out of network coverage _____
9. Special instructions for filing claims: _____

Assignment of Insurance benefits

By signing this form I am voluntarily authorizing the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes _____ to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each particular claim.

I, _____, hereby authorize _____
(Name of insured) (Name of Insurance Company)

to pay and hereby assign directly to _____, all benefits, if any, otherwise payable to me for her services as described on this form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____, will be credited to my account in accordance with the above said assignment.

Insured's Signature: _____ Date _____