INSURANCE INFORMATION

As a convenience to you, we can bill your insurance company for the services we provide. You are financially responsible for charges that are not covered under your insurance plan.

Please fill out this form even if you have already provided a copy of your insurance card to the clinic or your counselor. Providing complete and accurate insurance provider information before your first visit is essential.

All required copayments, coinsurance and deductibles are due at the time of service or when we receive benefit statements or remittance advices from your insurance company.

If you have questions about your authorizations, coverage, copays, or deductibles, please call you insurance company.

Primary Insurance Company

Company Name: ________________________ (required)

Policy ID: ________________ (required)

Group No.: _______________ (required if applicable)

Policy Holder's Name: ________________________ (required)

Policy Holder's Gender: Female Male (circle one)

Policy Holder's Date of Birth: ___ month, ___ day, ______ year (required)

Policy Holder's Address: ____________________________________ (required)

City: _____________________ (required)

State: ____ (required)

Postal Code: ___________ (required)

Has your annual deductible been met for this year? Yes No

If your deductible has been met, what is the required copayment amount? $ ________

Has your annual out of pocket maximum been met? Yes No

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Secondary Insurance Company (if applicable)

Company Name: ________________________ (required)

Policy ID: ________________ (required)

Group No.: _______________ (required if applicable)

Policy Holder's Name: ________________________ (required)

Policy Holder's Gender: Female Male (circle one)

Policy Holder's Date of Birth: ___ month, ___ day, ______ year (required)

Policy Holder's Address: ____________________________________ (required)

City: _____________________ (required)

State: ____ (required)

Postal Code: ___________ (required)

Has your annual deductible been met for this year? Yes No

If your deductible has been met, what is the required copayment amount? $ ________

Has your annual out of pocket maximum been met? Yes No

Please take a picture of your insurance card(s) with your phone and upload the file(s) using the Insurance Card option in the client portal or bring a photocopy of your card(s) to your appointment. We must have a copy of the front and back of your card.

Employee Assistance Program (EAP) (if applicable)

By circling "Yes" below, you agree to provide a paper copy or photocopy of your authorization from your EAP/Insurance provider before services are rendered. We do not have access to that information unless you provide it. If the information isn't provided prior to your first appointment, we will bill your insurance provider as non-EAP appointments and you will be responsible to pay your portion of each claim submitted.

Please Note: We will only accept one EAP authorization per client. After your EAPs are exhausted your insurance provider can be billed. You will subject you to any charges related to your deductible not being met or copayment requirements.

All of the following fields are required:

Do you have employee assistance program benefits through your employer? Yes No

If yes, what is the name of the EAP provider? ______________________ (required)

Authorization Number: _________________________(required)

Authorized Sessions: __________(required)

Authorization Start Date: ___________________(required)

Authorization End Date: ____________________(required)