Kimberly A Gaines Counseling

39755 Murrieta Hot Springs Road, Suite D160

Murrieta, CA 92563

INSURANCE INFORMATION

Insurance Carrier

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_

(Insured is the person who carries the insurance. If insured person is the same as client, you may write “SAME”).

Health Insurance Provider: Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a deductible? Yes No If yes, amount of deductible: $\_\_\_ \_\_\_ \_\_\_\_

Have you met your deductible for the year? Yes No

Do you have a Co-Payment? Yes No If yes, the amount of your Co-Payment: $\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Authorization Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Assignment of Benefits

I hereby authorize payment directly to Kimberly Gaines, LMFT, of the benefits otherwise payable to me under the terms and conditions of my health insurance. I understand I am financially responsible to the above provider for the charges not covered by my insurance. I understand and agree that all accounts are due and payable at the time of service and that insurance is being billed as a courtesy. In insurance assigned cases, Kimberly Gaines, LMFT agrees to accept the charge determination of the insurance carrier as the full charge and I am only responsible for the deductible, co-payment, and non-covered services. If my insurance carrier denies payment for these services, I agree to be personally responsible for the payment.

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Client’s Name (Printed) Parent/Guardian’s Name and Relationship to Minor Client (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Parent/Guardian’s Signature Date

Release of Information

I authorize the release of any medical or other information necessary to process insurance claims or obtain additional/continued authorization for services. I understand that this release includes billing and clerical personnel who are also under legal obligation to maintain confidentiality.

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Client or Parent/Guardian’s Signature Date