**Hope within Healing Counseling Services, PLLC**
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# INSURANCE AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers, billing agents and/or other health practitioners as is required for authorization or billing purposes.

I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of client or parent if client is minor Date

## Insurance Information

### Primary Insurance

Name of Insured (policy holder) _____

Insured's Birthday_____

Insured's Address _____

City, State, & Zip _____

Insured Phone #_____

Relationship to Patient _____

Employer _____

Insured's Social Security # _____

Insurance Company _____

Policy ID # _____

Policy Group # _____

Phone # for Insurance _____

Patient's Name _____

Patient's Soc. Sec. # _____

Patient Phone # _____

Patient's Birthday _____

Patient's Address _____

City, State, & Zip _____

Co-pay Amount $ _____

Number of Visits Allowed _____

Pre-Authorization # _____

### Additional Insurance

Name of Insured_____

Insured's Birthday_____

Insured's Address _____

Phone#_____

Relationship to Patient _____

Employer _____

Date Employed _____

Insured's Social Security # _____

Insurance Company _____

Policy ID # _____

Policy Group # _____

Phone # for Insurance _____

**FOR OFFICE USE ONLY:**
Effective Date:_____ Benefits are Per Yr / Cal Yr:
Deductible $ Amt:_____Amt Met:_____
After Deductible : plan pays: _____% till _____OOP, then pays:_____
_____
Max Visits Per Yr:_____Max $$ Per Yr:_____LTM: _____
Covers: 90791 90834 90837 90846 90847
Claim form required?:_____EAP: _____Coord Benefits: Y N
Address to send claim:_____

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