Hope Crossing Christian Counseling, Inc.

Client Name:____ Date of Birth____/____/____
Last, First, MI

Primary Insurance Company:____

____ _________________________________
Subscriber ID Number Group Number

Subscriber (Primary Card Holder) Name:____
Relationship to Subscriber: (Circle One) Self Spouse Dependent
*** If Different From Client:
(_____)_____-_________ ____
Phone Address City State Zip

Social Security Number:_______-_____-_______ Date of Birth____/____/____ M__ F__

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Secondary Insurance Company:____

____ _________________________________
Subscriber ID Number Group Number

Subscriber (Primary Card Holder) Name:____
Relationship to Subscriber: (Circle One) Self Spouse Dependent
If Different From Client:
(_____)_____-_________ ____
PhoneAddress Address City State Zip

Social Security Number:_______-_____-_______ Date of Birth____/____/____ M__ F__

For Office Use Only

(_____)_____-_________ IN/OUT _________________________ _________
Benefit Check Phone Number Network Representative Name Time

$__________Deductible $_______Copay _______%Coins. $_______OOP Max

______Visits/calendar-benefit year Authorization Required? Y N

Covered Services: 90801 90806 90847 90846 90808 90853

M.H. Mailing Address:_____________________________

____

(_____)_____-_________ _____________________ __________________________
Auth. Phone Number Representative Name Authorization Code

_____________ ___/___/___ : ___/___/___ Client Informed:____/____/____
Number of Visits Auth'd Effective Date Expiration Date

Benefit Check By:____ Date____/____/____

Please read carefully and sign below:

I understand that Hope Crossing Christian Counseling, Inc. does not routinely bill insurance unless the provider is contracted with the Client's insurance plan. I understand I will be given a copy of my paid bill to submit to my insurance company for any out-of-network reimbursement on my current insurance plan.

I understand that if my provider is contracted with my insurance plan that I must provide Hope Crossing Christian Counseling, Inc. with a copy of my current insurance card and notify Hope Crossing Christian Counseling, Inc. immediately should my insurance plan terminate or change in any way. (plan, benefits, etc.)

I hereby authorize my insurance company to pay any benefits directly to Hope Crossing Christian Counseling the amount due for service rendered to me or my dependents.

I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account.

I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Hope Crossing Christian Counseling, Inc.

Guarantor Signature: ________________________________ Date:___/___/___