Health Insurance Information Form

Patient Name:			
Patient Address:	City:	State:	Zip:
Patient Birthdate:	Patient Phone Number:		
Relationship to Insured:			

Primary Insurance Coverage

Insurance Name:	Policy/ID #:	Group #:
Policy Holder's Name:	Policy Holder's Address:	Policy Holder's Birthdate:
		Policy Holder's Phone #:

My Deductible is:	My Copay is:
Authorization Required? ☐ Yes ☐ No	Authorization #:

Secondary Insurance Coverage

Insurance Name:	Policy/ID #:	Group #:
Policy Holder's Name:	Policy Holder's Address:	Policy Holder's Birthdate:
		Policy Holder's Phone #:

My Deductible is:	My Copay is:
Authorization Required? ☐ Yes ☐ No	Authorization #:

_____ **PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

Initials

I, the undersigned, authorize payment of medical benefits to Wellspring Counseling Center for any services furnished to me by its providers. **I understand that I am financially responsible for any amount not covered by my contract.** I also authorize release to my insurance company of any information necessary to process claims for service.

_____ **MEDICARE/MEDICAID AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

Initials

I, the undersigned, am requesting the payment of authorized Medicare/Medicaid benefits be made on my behalf to Wellspring Counseling Center for any services furnished to me by its providers. I authorize release to Medicare/Medicaid of any information necessary to process claims for service.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ _____

Signature of Patient/ Responsible Party **Date**