Client Insurance Information and Release

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to **New View Counseling, PLLC** for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or cancelled within 24 hours of the scheduled appointment time.

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney’s fees and collection expenses.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Social Security Number \_\_\_\_-\_\_\_\_\_-\_\_\_\_ Subscribers DOB \_\_\_/\_\_\_/\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**To be completed by Billing Office**

Date: \_\_\_/\_\_\_/\_\_\_ Spoke with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In Network or Out of Network

Policy effective: \_\_\_/\_\_\_/\_\_\_ Copay per visit: $\_\_\_\_\_\_\_\_ Coinsurance per visit: $ \_\_\_\_\_\_\_\_\_

Deductible amount: $ \_\_\_\_\_\_\_\_\_\_ Deductible met: $\_\_\_\_\_\_\_\_\_\_\_

Max Visits/Max Payable per Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Out of Pocket per Year \_\_\_\_\_\_\_\_\_\_\_\_\_

Exclusions to Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sessions Approved: \_\_\_\_\_\_

Authorization Dates: \_\_\_\_\_\_\_\_thru\_\_\_\_\_\_\_ Number of EAP Sessions\_\_\_\_\_\_\_\_\_