Client Insurance Form

I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered.

Policy Information

Insurance Company: _____

Member ID: _____

Priority: Primary

Policy Group (leave blank if unsure): _____

Plan Name (leave blank if unsure): _____

Policy Holder

Client Relationship: Self

Policy Holder Information (leave blank if Self)

Name:_____

Administrative Sex: Male

Date of Birth (m/d/yyyy): _____

Address 1: _____

Address 2: _____

Zip: _____

City/State: _____

Phone Number: _____

Acknowledgement:
I authorize Shared Vision Psychological Services to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Shared Vision Psychological Services if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Shared Vision Psychological Services and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

_____

Signature