



INSURANCE INFORMATION

(Please give your insurance card to the receptionist or therapist)

Name of Client: _____

Is client covered by insurance? Yes No **Is pre authorization for mental health benefits required?** Yes No

1. Primary Subscriber's Name:	Birth date: / /	Address (if different):	Home phone no. : ()
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Name of Primary Insurance	Subscriber's S.S. no.:	Policy no:	Group no:	Co -payment: \$
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Is this person a client here? Yes No

Occupation:	Employer Name and address:	Employer Phone no. : ()
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Client's relationship to subscriber: Self Spouse Child Other

2. Secondary Subscriber's Name:	Birth Date / /	Address (if different)	Home phone no. ()
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Name of Secondary Insurance	Subscriber's S.S.no:	Policy no:	Group no:	Co-payment: \$
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Occupation:	Employer Name and Address	Employer Phone No:
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Client's relationship to subscriber: Self Spouse Child Other

SIGNATURE AND CONSENT

I agree to the policies of the Samaritan Center described in the Counseling and Fee Agreement I understand that I am responsible to obtain pre-authorization when my insurance company requires it. I hereby authorize the release of all information with respect to myself or the client named above which may be requested by my insurance company in order for them to determine coverage. I certify that the above information in support of this claim is true and correct. My insurance benefits will be paid directly to the Center. I understand that my policy is a contract between myself and my insurance company. Charges incurred are my responsibility. I understand that I am responsible for charges that are not reimbursed by my insurance company.

I authorize payment of medical benefits to Samaritan Counseling Center for services described.

Client (Guardian) Signature _____ Date: _____