Insurance Information:

PLEASE PRESENT YOUR INSURANCE CARD SO WE CAN COPY FOR OUR RECORDS

Insurance Company: _____
Member ID: _____ (SS # for Magellan Clients)
Policy Group #: _____

Policy Holder Name: _____
Policy Holder Date of Birth _____ (required)
Policy Holder Gender: M F Policy Holder Relationship to Client: _____
Policy Holder Address if Different from Client: _____
_____

Client or Dependent Name if different from Policy Holder _____

Assignment of Insurance Benefits and Payment Guarantee:
With regards to using an insurance carrier for counseling services rendered by Living Hope Counseling Center (LHCC), I hereby assign, transfer and set over to LHCC all of my rights, title and interest to healthcare reimbursement. In the event that payment is received from more than one source causing overpayment for this period of counseling, I authorize application of the overpayment to any unpaid counseling bill for which I am responsible.

I hereby authorize LHCC to release to any insurance carrier coded diagnostic and procedural information necessary for the completion of my counseling claim for payment purposes. I release and authorize LHCC to discuss details of my counseling with my insurance carrier and/or designated review agent.

In consideration of the services to be rendered to myself or the patient, I agree to pay LHCC in accordance with the regular rates and terms of LHCC. I further agree to pay the account in full within 45 days from the date of billing unless satisfactory arrangements are made with my counselor.

Consultations:
Evaluation reports for insurance companies, schools, other physicians, court, probations, etc. may not be covered by insurance. If insurance denies payment, I understand I am responsible for payment of these services.

I acknowledge if I do not pay for services as agreed, no further services will be provided by LHCC, until my account is brought current.

_____ _____
SIGNATURE OF CLIENT **DATE**

_____ _____
SIGNATURE OF INSURED OR GUARANTOR **DATE**