

**Client Insurance Information
& Other Provisions**

Please print and fill out completely:

Client Name: _____ Date of Birth: _____ SSN: _____
Address: _____ City/State: _____ Zip: _____
Home phone: ____ (____) _____ Cell/Work phone: ____ (____) _____

INSURANCE COVERAGE:

Insurance Company Name: _____ Phone No: ____ (____) _____
Billing Address: _____ City/State: _____ Zip: _____
Subscriber Name: _____ DOB: _____
Subscriber ID#: _____ Group #: _____ SSN: _____
Subscribers Address: _____ City/State: _____ Zip: _____
Subscriber's Employer: _____ Subscriber's Work #: ____ (____) _____

SECONDARY INSURANCE:

Insurance Company Name: _____ Phone No: ____ (____) _____
Billing Address: _____ City/State: _____ Zip: _____
Subscriber Name: _____ DOB: _____
Subscriber's ID#: _____ Group #: _____ SSN: _____

Please identify the Person Responsible for Payment of account:

Name: _____ DOB: _____ SSN: _____
Address: _____ City/State: _____ Zip: _____

Responsible Party Employer: _____

Your relationship to person responsible for payment: (Please circle one): Self Spouse Child Parent

Release of Information Authorization to Third Party

I (we) authorize Deborah Carnett, M.Ed, M.S., LMHC to disclose case records (diagnosis, case notes, psychological reports, testing results, and other requested materials) to the above listed third party payer or insurance company for the purpose of receiving payment reimbursement directly to Deborah Carnett, M.Ed, M.S., LMHC.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice and after one year this consent expires. I (we) have been informed of what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to these conditions and have received a copy of this form.

I (we) understand that this authorization is not a guarantee of payment from my insurance company and that I (we) are ultimately responsible for payment of my account in a timely manner. If, for any reason, my insurance requires any completion of phases in treatment I (we) understand that it is the policy of Deborah Carnett, M.Ed, M.S., LMHC that I must pay for treatment and can, at a later date, apply to my insurance company for reimbursement.

Signature(s) of Person(s) Responsible for Payment

Date

Signature(s) of Person(s) or Guardian(s)

Date

