NEW HOPE CENTER

Client Insurance Information – Form B

(All information is strictly confidential and will only be released for processing insurance claims)

Client Information: (The primary person seeking treatment -- the claims will be submitted under this name.)

Last Name_____ First Name_____

Address_____

City_____ State_____ Zip_____

Phone: Home:_____ Work:_____ Cell:_____

Date of Birth (mm/dd/year) _____/_____/_____

If this person has been treated by another Behavioral Health Provider since the beginning of this calendar year, please indicate the number of sessions attended to date: _____

Insurance Subscriber's Information: (The individual cardholder who carries the insurance for the client)

1. Primary Insurance:

Insurance Co:_____ ID# _____

Behavioral Health Phone # (back of card):_____

Name of Subscriber: _____ Date of Birth (mm/dd/year) _____/_____/_____

Client's relationship to Subscriber: Self_____ Spouse_____ Child_____ Other_____

Authorization # _____ (Please confirm with your insurance provider, if prior authorization is required.

2. Secondary Insurance: (If applicable)

Insurance Co:_____ ID#: _____

Behavioral Health Phone # (back of card):_____

Name of Subscriber: _____ Date of Birth (mm/dd/year) _____/_____/_____

Employer:_____

Client's relationship to Subscriber: Self_____ Spouse_____ Child_____ Other_____

Co-Payment Amount: $ _____ (Please note: Co-payments are due at the time of service.)

Please have your insurance cards available for copying at your first session.

I authorize the release of any medical or other information needed to process insurance claims related to this client's care.

Signed: _____ **Date:** _____

For office use only: Dx Code: