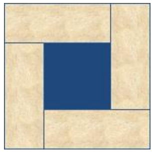

INVENTIVE COUNSELING

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INSURANCE INFORMATION

NAME OF CLIENT: ______________________ DATE OF BIRTH: ____________

CHOOSE WHICH ONE APPLIES:

1. ☐ I DO NOT HAVE INSURANCE
2. ☐ I DO HAVE INSURANCE, BUT DO NOT CARE TO USE IT AT THIS TIME
3. ☐ I DO HAVE INSURANCE AND WISH TO FILE CLAIMS

IF YOU SELECTED #3 ABOVE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

INSURANCE COMPANY NAME: ______________________ ACTIVE DATE: ____________

At this time, I am ONLY an in-network provider for Blue Cross/Blue Shield, and accepting the following plans: BCBS (PPO) AND INDEMNITY. If you intend on filing with other than the BCBS previously listed plans, I am considered OUT OF NETWORK and you will be expected to pay the normal rate in full at your session. Upon your request, I can provide you with a detailed receipt that may be used to request reimbursement from your insurance carrier. If you are not filing with BCBS, please skip this section.

TYPE OF POLICY: ☐ PPO ☐ INDEMNITY ACTIVE DATE: ____________

CONTACT NUMBER: ______________________

POLICY HOLDER NAME: ______________________

POLICY HOLDER ADDRESS: ______________________

RELATIONSHIP TO INSURED: ☐ SELF ☐ OTHER (LIST): ______________________

ID # ______________________ GROUP # ______________________

POLICY # ______________________ AUTH # ______________________

CO-PAY AMOUNT: $ ________ DEDUCTIBLE: $ ________ HAS IT BEEN MET? ☐ YES ☐ NO

CO-INSURANCE (AFTER DEDUCTIBLE HAS BEEN MET): ________ %

EXCUSIONS ON POLICY?: ☐ NO ☐ YES (PLEASE EXPLAIN): ______________________

____

I INDERSTAND THAT I AM AWARE OF AND RESPONSIBLE FOR PAYING FEES THAT ARE NOT COVERED BY MY INSURANCE PLAN, AND I AGREE TO PAY MY CO-PAYMENT AT THE TIME OF MY VISIT.

RESPONSIBLE PARTY: ______________________ DATE: ____________

RELATIONSHIP TO CLIENT: ______________________