Insurance & Billing Information Form

Name of Client Receiving Counseling: First:_______________________ MI________ Last:_______________________DOB: ______________

If you DO NOT have insurance or do not wish to file insurance, please sign below:

"I do not have insurance that covers mental health services or I do not wish to file claims for counseling services. I understand that full payment is due at the time of service by cash or check."

____ _________________________

Signature of Client or Parent/Guardian if Client is Minor Child Date

If you have mental health insurance coverage and want to seek reimbursement, please complete below:

PRIMARY INSURANCE COMPANY

Insured's Name: ____

SSN:______________________________ DOB:____________________

Co. Name:_____________________________ Plan Name:_____________

Policy Number:_________________________ Group Number:__________

Ins. Co. Phone:____

Fax:____

Address For Claims:____

City:__________________________ State:_____ Zip:___________

PRIMARY RESPONSIBLE PARTY

Give information about the person who is primarily responsible for paying for client's health care:

Name:____

Rel to Client: ☐ Self ☐ Father ☐ Mother ☐ Guardian ☐ Other

If address and phone information is not given for responsible party on this form or the INTAKE Form, please complete below:

Address:____

City:____________________ State:_____ Zip:_____________

Home: ( )_______________ Work: ( )_________________

Cell or Pager:__________ SSN:____________ DOB:____________

STATEMENT OF ACCEPTANCE REGARDING ASSIGNMENT OF BENEFITS

I hereby assign to EAST Counseling Services, Inc. (hereinafter referred to as ECS, Inc.), all insurance benefits otherwise payable to me resulting from the counseling services rendered to me (or to the minor child designated as "client" on this form) by ECS, Inc. I hereby instruct the applicable insurance companies to make payment covered by this assignment directly to ECS, Inc. I understand and agree that ECS, Inc. may elect to accept or not accept such assignment.

I agree that this assignment shall not be construed as relieving me from responsibility for any payment due and owing to ECS, Inc. for services rendered to the client. I will remit to ECS, Inc. any insurance proceeds due to ECS, Inc. which I may inadvertently be paid by any insurance company for claims arising out of treatment at ECS, Inc. I understand that if ECS, Inc. is not a member of my insurance network, my insurance company may make checks payable to me for reimbursement that is owed to ECS, Inc. I will assign such insurance reimbursement checks for services due ECS, Inc. directly to ECS, Inc. by delivering such checks to ECS, endorsed as "payable to EAST Counseling Services, Inc." or I will pay ECS, Inc. for services rendered. I am aware that if I do not provide ECS, Inc. with insurance reimbursement for services due, I will be given a 1099 tax form at the end of the year showing the insurance reimbursement as income.

I hereby give ECS, Inc. permission to release information necessary to coordinate care to the insurance company(ies) listed above. I realize that ECS, Inc. cannot protect my confidentiality once my records are released to an insurance company. A copy of this Assignment may be used when filing insurance claims and shall be as effective as the original.

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Signature of Responsible Party/Client/Parent if Client is Minor Child Date