ELISABETH A. EDWARDS, MA, LMHC, LMFT

INSURANCE BILLING INTAKE AND RELEASE

In order to initiate insurance billing, please clearly fill out the following information.

CLIENT INFORMATION:

NAME: _____

ADDRESS: _____

_____

DOB: _____/_____/_____ SEX: _____ MALE _____ FEMALE

CELL PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION:

COMPANY: _____

ID #: _____ GROUP #:_____

CUSTOMER SERVICE MENTAL HEALTH #: _____

INSURANCE-HOLDER INFORMATION:

NAME: _____

ADDRESS: _____

_____

DOB: _____/_____/_____ SEX: _____ MALE _____ FEMALE

RELATIONSHIP TO CLIENT: _____ SPOUSE _____ CHILD _____ PARENT _____ OTHER

I hereby authorize the release of any information necessary to review and process claims to the above named insurance company. I authorize payment of claims submitted to be sent directly to the provider of services. I understand that insurance may not reimburse for counseling services provided, and that payment for services provided is still my responsibility. My signature indicates that this and all other information listed is true.

SIGNATURE: _____ DATE: _____

- Office Use Only -

THERAPIST NAME: _____

DSM V: _____