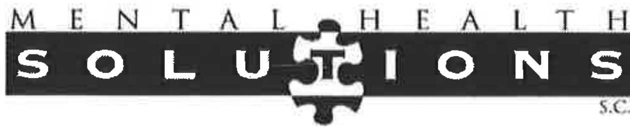

NEW CLIENT INSURANCE INFORMATION

Please Provide Us With the Current Insurance Card(s)

PRIMARY INSURANCE

Insurance Company: ___________________________

Policy Holder Name: ___________________________

Policy Holder Date of Birth: _____________________

ID #: ____

Group #: ____

Client Relationship to Policy Holder:

____

SECONDARY INSURANCE

Insurance Company: ___________________________

Policy Holder Name: ___________________________

Policy Holder Date of Birth: _____________________

ID #: ____

Group #: ____

Client Relationship to Policy Holder:

____

DOES YOUR INSURANCE COMPANY REQUIRE PRIOR AUTHORIZATION FOR SERVICES?

YES___ NO___

If Prior Authorization is Required and the Client or Client's Agent Fails to Contact the Insurance Provider to Obtain the Authorization, the Client Accepts Full Financial Responsibility for Any and All Charges.

Please check the boxes below to confirm you have read or been offered the Copayment Policy and the Consumer Rights of Individuals Receiving Treatment. If you would like copies of these documents, please ask the front administrative staff.

☐ Acknowledge of Copayment Policy ☐ Acknowledge of Consumer Rights of Individuals Receiving Treatment

I hereby attest that the above provided information is accurate. I agree to obtain any prior authorization(s) needed by my insurance(s). I authorize insurance(s) to make payments directly to: Mental Health Solutions, S.C.. I also authorize the release of any medical information necessary to process my insurance claims if applicable.

Signature of Client (14 and Older): ___________________________________ Date: _________________

Printed Name of Authorized Person: ____

Signature of Authorized Person: ___________________________________ Date: _________________

If signed by a person other than the patient, stated authority to do so (Circle one):

Legal Authority   Legal Guardian   Next of Kin   Parent of Minor   Power of Attorney