Vancouver
Integrative Counseling

Insurance Information for Verification of Benefits

Client Name: __________________________ Client Date of Birth: _____/_____/________

Therapist: _____________________________ Client Phone #: (   ) _______ - _____________

I. Primary Insurance Co.: ____

Policy Holders Name: ___________________________ Policy Holders Date of Birth: ____________________

Policy Holders Address: ________________________________ City/State/Zip: _________________________________

ID Number: ___________________________ Group Number: ___________________________

Client Relationship to Primary Insured: SELF____ SPOUSE____ CHILD____ OTHER_____________

II. Secondary Insurance Co.: ____

ID Number: ____________________________ Group Number: ___________________________

Client Relationship to Secondary Insured: SELF____ SPOUSE____ CHILD____ OTHER_____________

Policy Holders Name: ___________________________ Policy Holders Date of Birth: _________________

Policy Holders Address: ____

List persons authorized to discuss your billing account with Integrative Trauma Treatment Center and Sunrise Medical Billing including but limited to making payments, supplying service dates, providing account status, arranging payments and/or disclosing billing information.

1) ____ (relationship to client) ____________________________

2 ____ (relationship to client) ____________________________

3) ____ (relationship to client) ____________________________

Additionally, I authorize the release of any medical or other information necessary to process claims. I understand I am responsible for any charges not covered by my insurance. I also request payment of government benefits either to myself or the party who accepts assignment. My signature also indicates that I authorize payment of medical benefits to the provider of services and the entity therein.

***PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD TO OUR OFFICE MANAGER OR YOUR PROVIDER

SIGNATURE: _________________________________ DATE: ______________________________

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