# Insurance Information

| **Patient Name** | Telephone # | Social Security # |
|---|---|---|
| **Address** | **City** **Zip** | |
| Gender: M F | **Date of Birth** | |
| **Insurance:** | | |
| **Insured Name** | **Relationship to Patient** | |
| **Insured Address** | **City/Zip** | |
| **Insured Social Security #** | **Insured Date of Birth** | |
| **Subscriber ID #** | | |
| **Group #** | **Insurance Co Telephone Number** | |

Insurance Assignment

I hereby authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I hereby authorize and request my insurance company to pay directly to Solace Counseling Associates any amount due on claims for services rendered to me. This assignment shall remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I further agree that I am responsible for any deductible, copay, co-insurance, or other balance not covered by my insurance carrier. I understand that I am responsible for advising the office of any changes to my insurance coverage and will be responsible for any amounts not covered due to failure of notification of insurance changes.

Patient Signature:_________________________________________ Date:_______________________

For Office Use only:

| **Authorization Required?** | **Y N** | **Auth #_____________________** |
|---|---|---|
| **Ded:_________** | **Copay/Coins:________** | **Payor ID:__________________** |
| **Date:_________** | **Rep:______________________** | **By:___________** |