

Client Name _____

Child
Please Print

Financial Information

Mother's Personal Income (# of Dependents)

Father's Personal Income (# of Dependents)

Insurance Information

Primary Insurance Company

Secondary Insurance Company

Address

Address

Insurance Company Phone #

Insurance Company Phone #

Policy Number

Policy Number

Effective Date

Effective Date

Policy Owner's Name Date of Birth

Policy Owner's Name Date of Birth

Policy Owner's SSN

Policy Owner's SSN

Employer

Employer

Doctor Referral (name) Yes No

Primary Care Physician

Client's relationship to insured

I assign and authorize direct payment of all benefits due for client services to NORTHLAND COUNSELING SERVICES. A copy of this assignment may be used in lieu of the original. NORTHLAND COUNSELING SERVICES may release such information as may be necessary and pertinent to the insurance companies names in those information documents to secure payment for services.

If I do not authorize NORTHLAND COUNSELING SERVICES to bill my insurance company, I will be responsible for the full cost of services.

All forms must be filled in completely in order for us to file the claim with your insurance company for proper reimbursement.



Signature (relationship to the insured)

Date

For Office Use Only

Client ID: _____

Assigned Therapist: _____

Diagnosis: _____

Open Date: _____

Funding Coverage Type: _____

Problem Code: 1_2_ 3_ 4_