

Client Insurance and Billing Information
(Please present insurance card to be copied by provider)

Client(s) Information (person / persons we will be seeing)

Client Name(s) _____ DOB: _____
(individual or couples names)
_____ DOB: _____

Client Address: _____

City/State/Zip: _____ Home Phone #: _____

Client Social Security Number: _____ Wk/Cell Phone #: _____

PRIMARY INSURANCE INFORMATION (person that holds the insurance policy)

Name of Insured: _____ Insured's DOB: _____

Insured's Address _____ Home Phone #: _____

City/State/Zip _____ Cell Phone #: _____

Name of Insured's Employer _____ Work Phone #: _____

Relationship to Client (please circle one): Self Spouse Parent Other

Insured's Social Security number: _____ Insurance Policy #: _____

Insurance Company Name: _____ Group #: _____

Ins. Mental Health Phone #: _____ Authorization #: _____

_____ Please Note: Insurance companies often require clients to obtain preauthorization before the first appointment. You are responsible for obtaining the initial authorization. Before you are seen for the first appointment we must have the authorization information (i.e. authorization number and/or letter) given to you by the insurance company as well as a copy of your insurance card. We suggest that you confirm your outpatient mental/behavioral health benefits (deductible, co-pay, which providers in our office are covered, etc.) before arriving for your first appointment.

_____ I have read and agree to all payment and policies of LCS. I acknowledge that I am responsible for all charges whether or not insurance pays. I hereby assign all medical benefits to LCS and acknowledge that a photo copy of this assignment is valid as original. **I understand that insurance companies do NOT pay for missed appointments.**

_____ I authorize LCS to release confidential information regarding my treatment and diagnosis to my insurance company or managed card program.

Patient Signature (or Legal Guardian)

Date