RESOURCE COUNSELING CENTER INSURANCE/THIRD PARTY AUTHORIZATION

Billing Information Please provide name and contact information for responsible party.

Name: _____ _____ _____

(First) (M.I.) (Last)

Date of birth: _____ _____ _____

(Month) (Date) (Year)

Address: _____

(Number, Street, P.O. Box)

_____ _____ _____

(City) (State) (Zip)

E-Mail _____

Phone _____ _____ _____

(Cell) (Work) (Land Line)

Insurance Information (Please check type of policy and identify.

Marital status (required for insurance) ____Single ____Married

Policy Holder's Name _____ Policy Holder's Social Security Number_____

_____ Blue Cross/ Blue Shield _____ Policy Number

_____ Medicare _____ Medicare Number

_____ Medicaid _____ Medicaid Number

_____ Other Insurance _____ Company Name & Number

ACKNOWLEDGEMENT and AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of benefits for services received to ReSource Counseling Center. I take responsibility for payment of all fees not covered by insurance or other third parties for services received. I understand that co-payments, co-insurances and fees that will be applied to deductibles are due at the time of each visit.

I agree to receive counseling under the terms stated above.

Name of counselee:

_____ _____ _____

(First) (Middle Initial) (Last)

_____ _____

(Signature) (Date)

If authorization is by a parent, guardian or Healthcare Power-of-Attorney (HPOA) or if someone other than the counselee is responsible for payment:

I authorize that the above named person receive counseling and that insurance and other third party payments be remitted to ReSource Counseling Center under the terms stated above.

_____ _____ _____ _____

First Middle Initial Last Relationship to counselee

_____ _____

(Signature of parent, guardian or HPOA) (Date)