Northwest Counseling, PLLC
Insurance Information/Assignment of Benefits

Patient Information

Name_____Date of Birth_____

Policyholder Information

Name_____Date of Birth_____

Address_____

Phone_____ Social Sec. #_____Employer_____

Client's relationship to policyholder: Self_____ Spouse_____ Dependent_____ Other_____

Insurance Company_____EAP provider_____

Policy #_____ Group #_____ Co-pay_____ Deductible_____

Authorization # _____ Date of Authorization_____ #sessions_____

Deductible yes_____no_____ Has it been met? yes_____no_____ Deductible due_____

Phone # of Insurance Company to verify coverage_____

Secondary Insurance? Yes____ No____ Information if yes_____

_____

Fee amount:_____Expected insurance payment:_____Client's payment per visit:_____

I hereby authorize Northwest Counseling, PLLC to release information acquired in the course of my treatment which may be required to obtain reimbursement services or to obtain benefits for which I may be eligible. I agree to pay the above indicated amount and understand that I am fully responsible for services not covered by my insurance company. I authorize payment directly to my clinician or NWC, PLLC for services rendered in the course of my or my dependents treatment.

Signature of Insured_____ Date_____

Clinician_____ Date_____