

Northwest Counseling, PLLC
Assignment of Benefits/Payment Information

Patient Information

Name _____ Date of Birth _____

Payer Information Name on Credit Card _____

Credit Card # _____

Expiration Date _____ / _____ CVS Code _____

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 the use of the CC on file. 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 _____