gateways counseling & consulting center
care • compassion • competence

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FINANCIAL INFORMATION FORM

A. Identification

Your name: _____ Date of Birth: _____ Age: ____

Social Security #: _____ Home Street Address: _____

_____ Apt: ___ City: _____

State: _____ Zip: _____ Home/evening phone: _____

Insured's/policy holder's name: _____

Employer: _____ Work phone: _____

B. (If applicable) Spouse's name: _____

Date of birth: _____ Social Security #: _____

Occupation: _____ Employer: _____

C. Insurance Coverage:

Name of health insurance carrier/company: _____

Name of subscriber (if different from patient): _____

Identification/agreement/policy #: _____

Group or enrollment #: _____ Effective date: _____

Location/address to send claims: _____

_____ Provider's phone #: _____

D. Assignments of benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client (or parent/guardian's) signature Date
Indicating agreement to all of the statements above

E. I understand that I am responsible for all charges, regardless of insurance coverage. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client (or parent/guardian's) signature Date
Indicating agreement to all of the statements above