



Insurance Information and Consent to Contact

Client Information:

Name _____ Date of Birth _____

Address _____

Insurance and/or Employee Assistance Program (EAP) Information:

Name of Employee Assistance Program (EAP) _____ Authorization # _____

of sessions authorized _____ start date _____ end date _____

Name of Primary Insurance Company _____

ID Number _____ Group Number _____

Payer ID # _____ Subscriber's Name _____

Address to Submit Claims (found on the back of the insurance card) _____ Subscriber's Date of Birth _____

Subscriber's Relationship to Client _____

Name of Secondary Insurance Company _____

ID Number _____ Group Number _____

Payer ID # _____ Subscriber's Name _____

Address to Submit Claims (found on the back of the insurance card) _____ Subscriber's Date of Birth _____

Subscriber's Relationship to Client _____

Authorization for the Disclosure of Protected Health Information to Third Party

By signing below you authorize the Clinic for Christian Counseling LLC to contact Insurances/EAPs listed above.

Other party/parties you authorize the Clinic for Christian Counseling LLC to contact for funding of services:

Name _____ DOB _____ Phone _____

Name _____ DOB _____ Phone _____

You understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and your health information may be re-disclosed by such person(s) and/or organization(s) without obtaining your authorization. You may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency you authorized to release information. You have a right to inspect and receive a copy of the records to be disclosed. You have a right to receive a copy of the authorization. You have a right to refuse to sign the authorization. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. If this authorization is for the purpose of filing an insurance claim, all benefits will be paid directly to the Clinic for Christian Counseling. Authorization expires after payment owed by third party payor is complete.

You have had the opportunity to review and understand the content of this authorization form. By signing this authorization, you are confirming that it accurately reflects your wishes.

Client's Signature

Date

Partner/Parent/Guardian Signature

Date