DAYSPRING COUNSELING INSURANCE AUTHORIZATION FORM

PATIENT INFORMATION

Patient name: Social Security Number:
Street Address: Date of Birth: Marital status: S M W SEP D
City/State: Zip: Telephone Number:

PATIENT EMPLOYER INFORMATION

Employer name: Telephone Number
Employer street address: City/State: Zip:
Patient's occupation:

INSURED PERSON (IF NOT PATIENT)

Name: Telephone Number: Date of Birth:
Street address: City/State Zip: S.S.#

INSURED PERSON EMPLOYER INFORMATION

Employer:
Employer street address City/State: Zip:

INSURANCE

#1 Primary insurance company name:
Primary insurance company address:
ID Number: Plan: Group:
Subscriber's name: Relationship to patient:
Subscriber's employer: Type of Insurance: HMO PPO MC TRADITIONAL

#2 Secondary insurance company name:
Secondary insurance company address:
ID Number: Plan: Group:
Subscriber's name: Relationship:
Subscriber's employer: Type of Insurance: HMO PPO MC TRADITIONAL

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize DaySpring Counseling, LLC. to apply for benefits on my behalf for covered services rendered or supervised by DaySpring Counseling, LLC. I authorize payment of medical benefits from my insurance company be made directly to DaySpring Counseling. I authorize the release of any medical information necessary to process this claim. I certify that the information that I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing.

Signature: ______________________________ Date: ____________________

PLEASE PROVIDE OUR OFFICE STAFF WITH YOUR INSURANCE CARD SO A COPY MAY BE MADE.
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