SPRING LIFE COUNSELING, LLC

www.springlifecounselng.com 225.603.3443

HEALTH INSURANCE INFORMATION

Dear Client, We look forward to seeing you and we will gladly file your sessions with the counselor to your insurance company. However, we do not verify coverage or call to get the information concerning your coverage for you. You must call the phone number(s) on your health insurance card to get the following information PRIOR to your first session. Without ALL questions on this form answered by your Insurance Company, you will be responsible for the full session fee.

Name: _____ Date of Birth: _____
Insured's Name: _____ SS#: _____
Name of Insurance Company: _____ Effective date: _____
Insured's ID number: _____ Group Numbers: _____

You must call the number on your insurance card and ask these questions.
Ask for a reference number regarding your phone call. Ref. # _____

Do I have out-patient mental health benefits? Yes_____ No_____

Is Allison Schoonmaker (Spring Life Counseling, LLC) on my provider list? Yes____ No____

If no, do I have any "out of network" benefits? Yes_____ No_____ (Write what those benefits are on the back of this form.)

Do I have a deductible to meet prior to benefit coverage? Yes_____ No_____

What is the amount of my deductible? $_____

How much of that deductible have I met? $_____

Do I have a co-payment for mental health benefits? Yes _____ No_____

If so, what is my co-payment amount per session? $_____

How many sessions are allowed per calendar year? _____

Is prior authorization needed for counseling? Yes_____ No_____

If so, authorization number? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: _____ DATE: _____