NEW STEP COUNSELING

Ed Fitzpatrick, MSW, LICSW
329 South Sequim Ave., Ste. B
Sequim, WA 98382
360.808.4000

INSURANCE INFORMATION FORM

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

1. Client's Name: _____DOB:_____
2. Name of Insured: _____DOB:_____
3. Address of Client/Insured:_____

   _____
4. Insurance ID:_____
5. Relationship of Client to Insured: _____
6. Check one of the following: [ ]Insurance [ ]Managed Care [ ]EAP

   _____
7. Managed Care/Insurance Company: _____

   MEMBER ID: _____ Group Number: _____
8. Is there another health benefit plan or insurance company providing coverage? [ ]Yes [ ]No

   If Yes, complete the following:

   Name of Insured: _____

   Other Insured's Policy:_____Other Insured's D.O.B. _____

   Other Insured's Group Number: _____

   Other Insurance Plan Name: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize New Step Counseling and any member of the clinical staff of the Center to provide a summary of care and assessment information regarding evaluation and/or treatment for the purpose of evaluating and processing claims for benefits. Furthermore, I authorize payment of mental health benefits directly to New Step Counseling for services rendered. New Step Counseling will file my claim for me and re-file if necessary. I will make all co-payments in accordance with my insurance contract. New Step Counseling will not assume responsibility for collecting on my insurance claim or negotiating settlement on a disputed claim. I realize I may be asked to make payments in accordance with the adjusted fee scale if my insurance company delays or refuses to pay claims. New Step Counseling will make any necessary adjustments to my account when insurance payments are received. I understand that payment for services rendered is ultimately my responsibility.

Signed_____Date:_____

Client or Parent/Legal Guardian