# Insurance Information

**(PLEASE PRINT)**

## Primary Insurance Company_____

**Address_____**
**City_____State_____ZIP:_____Phone:_____**
**Policy Holder's Name_____**
**SSN_____Date of Birth_____**
**Patient's Relationship to Policy Holder_____**
**ID#_____ Group#_____**
**Policy Holder's Employer_____**

## Secondary Insurance Company

**Address_____**
**City_____State_____Phone_____**
**Policy Holder's Name_____**
**SSN_____Date of Birth_____**
**Patient's Relationship to Policy Holder_____**
**ID#_____ Group#_____**
**Policy Holder's Employer_____**

## Authorization to Release Information and Assignment of Benefits

**Release Information: I authorize the release of clinical information necessary to Process my insurance claim and to request further authorization for care by the Insurance company.**

_____ _____

**Signature of Patient (Parent if a Minor)** **Date**

**Assignment of Benefits: I authorize payment of benefits to Sara Hopkins, LCSW for Services provided.**

_____ _____

**Signature of Patient (Parent if a Minor)** **Date**

## Cancellation and Payment Policy

Appointments are normally scheduled at least once a week in advance, with Every effort made to arrange a time to accommodate your needs. If at all possible, 24-hour notice is requested, except in cases of emergency. Missed appointments will be billed to the patient, and not to the insurance company. Fees for services services are rendered unless other arrangements have been made in advance.

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**Patient Signature** **Date**