Client Insurance Form

If you do not have, or do not want to use insurance benefits, you do not need to fill out this form. If you do want us to bill your insurance, please complete this form.

Policy Information

Insurance Company:

Member/Beneficiary ID:

Priority:

PrimarySecondaryTertiaryQuaternary

Policy Group:

Plan Name:

Policy Holder

Client Relationship:

SelfSpouseChildLife PartnerOther Relationship

Insurance Card

Provide photos of the front and back of your insurance card to send to your practice. You can take a photo with your camera or upload a file.

Release of Information & Assignment of Benefits

I understand and agree to the following:

- I authorize the release of information from my medical record to the insurance company or other third-party payer named above. This information shall include all information necessary to submit and process claims, such as my name, date of birth, address, medical diagnosis, and services provided to me.
- If the practice has already shared information with the insurance company or other third-party payer at the time I revoke this authorization, it is too late to prevent that information from being shared.

- This authorization is necessary for the practice to determine eligibility for treatments or benefits or to pay for treatments I receive, but the practice cannot condition treatment on the provision of this authorization.
- This authorization shall be effective for 1 year from the date of my signature, unless I contact the practice in writing any time prior to then to revoke.
- If you are using Medicare benefits, you also agree to the following: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.
- In consideration of the services provided to me, I assign all benefits to the practice, if accepted, and authorize this insurance company to make payments directly to the practice and its affiliates on my behalf.

Acknowledgment

I authorize Shine a Light Counseling Center to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Shine a Light Counseling Center if accepted, and authorize my insurance companies, Medi-Cal, or other third-party payers to make payments directly to Shine a Light Counseling Center and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

Signed By: