Health Insurance Information and Authorization

In order for Back to Balance Counseling, LLC to process your health plan or health insurance claims, the following release must be signed and kept on file. You may also be asked to provide a copy of your insurance card. **Please inform me of any changes in your health care coverage while you are receiving services. Please note: The client is responsible for the cost of services should the insurance company deny payment or if incorrect insurance information is provided.**

I authorize Back to Balance Counseling, LLC to release any information required in the process of applications for financial coverage for the services rendered. Please refer to the *Payment and Insurance Reimbursement* section in the **Informed Consent and Policies and Procedures** for a full explanation.

I authorize payment of medical benefits to Back to Balance Counseling, LLC for mental health services.

____ _____________________

Client or Authorized Person Signature Date

Type of Insurance (circle): BCBS PPO **OR** BCBS Blue Choice PPO

Insured's name (as it appears on the card):_____________________________________

Insured's address:____

Insured's date of birth:______________ Relationship to client:______________________

Insured ID #:_________________________________ Insured Group #:________________

Employer name:____

Insurance telephone #s on back of card:____

Deductible amount: $____________________ Co-pay amount: $_____________________

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