**Client Name**_____ **Adult**

**Financial Information** **Please Print**

Personal Income | Family Income | (# of Dependents) | Fee Assigned

## Insurance Information

| | |
|---|---|
| Primary Insurance Company | Secondary Insurance Company |
| Address | Address |
| Insurance Company Phone # | Insurance Company Phone # |
| Policy Number Group Number | Policy Number Group Number |
| Effective Date | Effective Date |
| Policy Owner's Name Date of Birth | Policy Owner's Name Date of Birth |
| Policy Owner's SSN | Policy Owner's SSN |
| Employer | Employer |

Doctor Referral (name) □Yes □No | Primary Care Physician | Client's relationship to insured

I assign and authorize direct payment of all benefits due for client services to Northland Counseling Services. A copy of this assignment may be used in lieu of the original. Northland Counseling Services may release such information as may be necessary and pertinent to the insurance companies names in those information documents to secure payment for services.
If I do not authorize to bill my insurance company, I will be responsible for the full cost of services.

**Signature (relationship to the insured)** **Date**

All forms must be filled in completely in order for us to file the claim with your insurance company for proper reimbursement.

For Office Use Only

Client ID:_____ Open Date:_____
Assigned Therapist:_____ GAF Score:_____
Diagnosis:_____ Funding Coverage Type:_____

Problem Code: 1_____2_____3_____4_____