Client Name_____ **Child**

Please Print

Financial Information

Mother's Personal Income (# of Dependents) Father's Personal Income (# of Dependents)

Insurance Information

Primary Insurance Company	Secondary Insurance Company
Address	Address
Insurance Company Phone #	Insurance Company Phone #
Policy Number	Policy 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 NORTHLAND COUNSELING SERVICES 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_____