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: ____________________ Funding Coverage Type: ____________________
Diagnosis: ____________________