



## **Health Insurance Information and Authorization**

In order for Autumn Leaf 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 payment of medical benefits to Autumn Leaf 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: \$ \_\_\_\_\_

**5757 S. Madison Street, Hinsdale, IL 60521  
jorie@autumnleafcounseling.com ~ 630.346.6713**