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.

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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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