BOWIE COUNSELING SERVICES

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INSURANCE INFORMATION

PATIENT:_____ DOB:_____ SSN_____

1. Primary Insurance Information

Who is responsible for this account? _____

Relationship to patient? _____

I the undersigned certify that I (or my dependent) have insurance coverage with _____

_____and assign directly to **Bowie Counseling Services** all insurance benefits. If the insurance company pays me for services rendered, I agree to pay **Bowie Counseling Services**. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize _____(Psychotherapist) to release all information necessary to secure payment of benefits. I authorize the use of this SIGNATURE on all insurance submissions.

Patient (or guardian) Signature:_____

Relationship to Patient::_____Date:_____

Witness:_____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Bowie Counseling Services** for any services furnished me by their psychotherapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and Its Agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the psychotherapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:_____Date:_____

Witness:_____