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Green Leaves Counseling
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Insurance Information

Your name _____
Date of birth _____
SSN _____

Insurance Company _____ ID number _____
Policy holders name _____ Group number _____
Policy holder's date of birth _____ SSN _____
Policy holder's address: _____
Policy Holder's phone number: () _____ - _____
Policy Holder's employer _____

Primary Care Physician's Name _____
Phone number _____
May this doctor be consulted for continuity of care? Yes ___ No ___

BE ADVISED THAT BY SIGNING FOR US TO BILL YOUR INSURANCE COMPANY YOU UNDERSTAND THAT AUDITORS FROM THAT COMPANY HAVE THE RIGHT TO COME IN AND INSPECT AND READ YOUR FILE. ALL YOUR DIAGNOSTIC INFORMATION IS SUBMITTED TO THEM AFTER EACH SESSION. CONFIDENTIALITY IS NOT PRESERVED WHEN INSURANCE COMPANIES ARE BILLED. IF YOU DO NOT WANT US TO BILL YOUR INSURANCE COMPANY YOU WILL BE RESPONSIBLE FOR THE FULL COST OF SERVICES AT EACH SESSION.

CLIENT ACCEPTS THE ABOVE STATEMENT AND WISHES TO BILL INSURANCE

CLIENT DECLINES TO HAVE INSURANCE BILLED FOR SERVICES AND WILL PAY THE FULL COST OF SERVICES AT THE TIME OF EACH SESSION

Client signature

Date