

Dana Hunt Unruh MS, LCPC
Green Leaves Counseling
208-855-2295
Insurance Information

Your name _____

Date of birth _____

SSN _____

Insurance Company _____ Policy number _____

Policy holders name _____ ID number _____

Policy holder's date of birth _____ SSN _____

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