



Insurance Information:

Client Name: _____ Medical Record #: _____

Primary/Secondary Insurance Company Name: _____
(Circle)

Address of Insurance Company: _____

Contact Name/Phone Number: _____

Policy Holder Information:

Name of Insured/Relationship to client: _____

Birth date of Insured: ____/____/____ Gender of Insured: M / F

Social Security # of Insured: ____-____-____ Effective Date of Policy: ____/____/____

Policy Number: _____ Group Number: _____

Employer of Insured: _____

Plan/Program: _____

Please check one and sign below:

_____ I would like for 3-C Family Services to assist in filing my insurance claim using "Out of Network" options. I authorize 3-C Family Services to communicate with my insurance carrier regarding treatment. I understand that 3-C Family Services will follow HIPAA guidelines regarding confidentiality and that only necessary information will be provided when requested by my insurance. I also understand that I will not be notified of such communication unless specifically requested by me in writing.

_____ I will either file independently or will not be using insurance benefits at this time.

Parent/guardian signature

Date

This is strictly a confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

(rev. 10/06)