Karen Bradley, LCPC
Bradley Counseling Clinic
208-283-2481
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