MC Wellness
LIVE WELL. DO BETTER.

Insurance Information

I hereby authorize MC Wellness (Facility), to contact my insurance carrier (shown below) in order to determine eligibility for counseling services. I understand that my insurance carrier will be billed for services rendered at MC Wellness on behalf of my treating counselor. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered at MC Wellness by any one of the counselors, I will, within five days of receipt of this check, make payment in the amount of said check to MC Wellness to the order of the providing counselor.

The following also applies to the use of my insurance to cover the cost of services rendered:

Authorization to Release Medical Information for Billing

- I hereby authorize the release of any information regarding services by the counselor to process insurance claims and allow a photocopy of my signature to file insurance claims.

Assignment of Insurance Benefit

- I hereby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the counselor made directly to the counselor.

Financial Responsibility

- If I am utilizing an "out of network" provider for the services rendered by the counselor, I understand, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered.
- I understand that failure of payment for service will result in discharge from services at MC Wellness and any counselors working in this office.

Authorization for the Release of Medical Information For Treatment

- I hereby authorize MC Wellness/Counselor to obtain and release copies of my counseling record for the purpose of further treatment and evaluation.

Insured's Name: _____ Patient Name: _____

Insurance Name: _____ Relationship to Patient: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insured Date of Birth: _____ SSN #: _____ Employer: _____

Insured Address: _____ City: _____ State: _____ Zip: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Type: ( )PPO ( )POS ( )HMO ( )MEDICARE ( )MEDICAL ( )Other

Primary Insurance: _____ Any Secondary Insurance (if so, please state): _____

Member ID#: _____ Group#: _____ Copay amount: _____

Patient Name: _____ Date: _____ Insured Signature: _____