Insurance Form

Client Information

Legal Name: ______________________

Date of Birth: ______________________

Race: ______________________

Address:

Street Address ______________________

city   State   Zip Code

Cell Phone: ______________________

Email Address: ______________________

Emergency Contact Information:

____

Name   Relationship   Phone Number

Do you have a legal guardian?

Primary Insurance Policy

Insurance Company: ______________________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________
(if different from client)

Relationship to Client: ______________________

Employer: ______________________

Subscriber/
Member ID #: ______________________

Group #: ______________________

Provider Phone:
Number *(back of card)* ______________________

Is this is a Medicaid/Medicare Policy? ☐ Yes ☐ No

***Please send a copy of the insurance card (front and back) with the completed form**

Secondary Insurance Policy (*if applicable*)

Insurance Company: ______________________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________
(if different from client)

Relationship to Client: ______________________

Employer: ______________________

Subscriber/
Member ID #: ______________________

Group #: ______________________

Provider Phone:
Number *(back of card)* ______________________

Is this is a Medicaid/Medicare Policy? ☐ Yes ☐ No

***Please send a copy of the insurance card (front and back) with the completed form**

Authorization to Release Information

I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor; 2) to verify insurance coverage; 3) to file a claim for insurance benefits related to professional services rendered.

Client/Financially Responsible Party
Signature: ______________________   Date ______________________

Email: ______________________

A member of our finance team will be contacting you to discuss the details of your or your loved one's benefits, cost of treatment, explain the process of obtaining authorization from the insurance company while you or your loved one is receiving treatment, and answer any questions you may have.

We strongly encourage the financially responsible party to be someone other than the client. HopeWay wants the client to focus on their mental health treatment and not be distracted by authorization of treatment. If you would like the finance team to contact someone else other than yourself, please provide their information below:

Name of Finanically Responsible:
Party ______________________

Relationship to Client: ______________________

Email: ______________________

Cell Phone: ______________________