**INSURANCE INFORMATION FORM** Client Name:

|  |  |
| --- | --- |
| PRIMARY INSURANCE | SECONDARY INSURANCE |
|            Insurance Company Telephone           Policy ID Number Group Number     Policyholder Name (If same as client, just write SELF)     Address      City, State & Zip           Telephone Social Security NumberPolicyholder’s Date of Birth Sex: [ ] M [ ] FRelationship of patient [ ] Self(1) [ ] Spouse(2) to policyholder: [ ] Dependent(3) [ ] Other(4) Start Date of Coverage      Copay      |            Insurance Company Telephone           Policy ID Number Group Number     Policyholder Name (If same as client, just write SELF)     Address      City, State & Zip           Telephone Social Security Number Policyholder’s Date of Birth Sex: [ ] M [ ] FRelationship of patient [ ] Self(1) [ ] Spouse(2) to policyholder: [ ] Dependent(3) [ ] Other(4) Start Date of Coverage      Copay      |

### Consent to Release Information

I **authorize** any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, peer review organization, insurance or reinsuring company, the Health Care Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give the group policyholder, my employer, third party administrator, my third party carrier or its legal representative, any and all such information.

I **understand** the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Debra Eng, MSW, LCSW, LCAS or as may be otherwise lawfully required or as I may further authorize.

## Payment of Benefits

I **authorize** that payment of medical benefits be made to the physician or organization listed on any claim submitted for any services furnished me by that physician or organization or to an agent contracted by Debra Eng as agent for that physician or organization, as directed by the physician or organization.

**I agree that these authorizations shall be valid until rescinded in writing or replaced at a later date.**

Client Signature (or Legal Guardian if client is a minor) Date