INSURANCE INFORMATION AND FEE AGREEMENT FORM

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

1. Client's Name: _____DOB:_____
2. Primary Insured: _____ DOB: _____
3. SSN of Insured: _____
4. Relationship of Client to Insured: _____
5. Required Co-Pay: _____ Deductible: _____
6. Check one of the following: ❑ Insurance ❑ EAP
7. Insurance / EAP Company:_____
8. Insurance / EAP Phone Number:_____
9. Insurance / EAP ID:_____
10. Group Number:_____
11. Is there a secondary insurance company providing coverage? ❑ Yes ❑ No

    If Yes, complete the following:

    Secondary Insurance Plan Name: _____

    Secondary Insurance Phone Number:_____

    Secondary Policy Number: _____ Group Number:_____

(Initial)_____As the insured party, I am responsible for any required deductible and Co-Pay amounts at the time of service. I further understand that Centus will assist in filing insurance claims & invoices to agencies, but that I am ultimately responsible for any and all charges.

RELEASE OF INFORMATION AUTHORIZATION OF PAYMENT FOR CLAIM BENEFITS

I hereby authorize the release of medical or any other information regarding evaluations and/or treatment of_____ for the purpose of evaluating and processing claims for benefits. I authorize payment of medical benefits to Centus, when applicable.

Signed: _____ Date signed: _____

Client or Parent/Legal Guardian