



Insurance Form

Client Information

Legal Name: _____

Cell Phone: _____

Date of Birth: _____

Email Address: _____

Address: _____

Emergency Contact Information:

Street Address

City State Zip Code

Name Relationship Phone Number

Do you have a legal guardian?

Primary Insurance Policy

Secondary Insurance Policy (if applicable)

Insurance Company: _____

Insurance Company: _____

Policy Holder's Name: _____

Policy Holder's Name: _____

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

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

Relationship to Client: _____

Relationship to Client: _____

Employer: _____

Employer: _____

Subscriber/
Member ID #: _____

Subscriber/
Member ID #: _____

Group #: _____

Group #: _____

Provider Phone:
Number (back of card) _____

Provider Phone:
Number (back of card) _____

Is this a Medicaid/Medicare Policy? Yes No

Is this a Medicaid/Medicare Policy? Yes No

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

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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 _____

Date _____

Signature:

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 Financially Responsible Party _____

Relationship to Client: _____

Cell Phone: _____

Email: _____