Counseling Solutions KC
633 E. 63rd Street, Suite 240
Office: 816-756-3505 **Appointment Line: 816-756-2984**

Insurance Information

Kansas City, Missouri 64110
Fax: 816-756-3058

Client Name: _____ **Date of Birth:** _____

PRIMARY INSURANCE:

Insurance Name: _____

Provider/Mental Health Phone No: _____

Member ID No: _____ Group No: _____

Policy Holders Name (if other than client): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____Gender (M/F): _____ Social Security: _____

Employer: _____ Relationship to Client: _____

SECONDARY INSURANCE:

Insurance Name: _____

Provider/Mental Health Phone No: _____

Member ID No: _____ Group No: _____

Policy Holders Name (if other than client): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender (M/F): _____ Social Security: _____

Employer: _____ Relationship to Client: _____

PLEASE READ AND SIGN THE FOLLOWING:

If you choose not to assign payment of benefits directly to your therapist, payment in full will be require at time of service.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to my therapist. I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the insurance claim form.

Signature: _____ _____ **Date:** _____
Client or Responsible Party

FOR OFFICE USE ONLY: Therapist _____ **DX:** _____ _____ _____