

BILLING AND INSURANCE VERIFICATION RELEASE FORM

Samaritan Counseling Center of the NW Suburbs
 800 N Hart Road, Suite #250
 Barrington, IL 60010

Counselor use: COUNSELOR: _____ GAF: _____
Amount Charged: \$ _____
DX Code: _____ FF _____ INS _____ FS \$ _____

Thank you for choosing Samaritan Counseling Center. By answering the questions below as completely as you can, you will help us to understand you and your situation more fully. **ALL INFORMATION IS CONFIDENTIAL.**

Client's Name:	First	MI	Last	Gender: <input type="checkbox"/> Male	Today's Date
				<input type="checkbox"/> Female	/ /
Address:			City	State	Zip
Home Phone # ()		Work Phone: # ()		Cell Phone # ()	
Spouse/Parent/Other Phone # ()			Email Address:		
Employer:			Social Security Number: _____ - _____ - _____		
Date of Birth: ____/____/____ Age: _____	Marital Status: Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Child/Adolescent <input type="checkbox"/>			Ethnic Background: African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other: _____ Caucasian <input type="checkbox"/>	

Please list all the members of your household (List any additional phone numbers on the back of form):

Name	Age	Date of Birth	Gender	Occupation/Employer	Religion

Which of the following categories best describes your household's total income before taxes last year? Please include from all sources such as salaries and wages, Social Security, retirement income, investments, and other sources.	<input type="checkbox"/> Less than \$20,000	<input type="checkbox"/> \$20,000 - \$39,999
	<input type="checkbox"/> \$40,000 - \$59,000	<input type="checkbox"/> \$60,000 - \$79,999
	<input type="checkbox"/> \$80,000 - \$99,999	<input type="checkbox"/> \$100,000 or more

WHO IS RESPONSIBLE FOR THIS ACCOUNT? Name(s): _____

Address/Phone (if different from client name above): _____

Social Security Number (if different from number provided above): _____ - _____ - _____

WILL YOU BE USING INSURANCE? Yes No IF YES, PLEASE PROVIDE YOUR INSURANCE CARD

Social Security Number of Primary Insured (if different from number provided above): _____ - _____ - _____

Birthdate of Primary Insured (if not listed above): ____/____/____

PATIENT'S OR AUTHORIZED PERSONS SIGNATURE -

- I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical benefits to Samaritan Counseling Center for services rendered.
- **I ACCEPT THE FINANCIAL RESPONSIBILITY OF ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PROCESSED THE CLAIM**

PLEASE SIGN _____ **DATE** _____

CANCELLATION & RETURN CHECK POLICIES

- Because counseling hours are reserved, Samaritan Counseling Center charges \$100 for canceled sessions when less than 24 hours notice is given.
- There will be a \$25.00 service charge on all returned checks.

I understand the policies as stated above. **Signature** _____ **Date** _____