Associated Counseling Group

♦ 748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
♦ 402-941-7016 ♦

INSURANCE INFORMATION
Client Relationship to insured __Self __Spouse __Child __Other:_____

Insured's Name(who carries the ins. policy)		SS#	Date of Birth (00/00/0000)
Address City State Zip Code			
Home Phone #	Work Phone #	Cell Phone #	Gender
Employer of insured or School		Check one: ____PT Student ___FT Student ___Employed	

INSURANCE POLICY INFORMATION- Please give your insurance card to the support staff to photocopy.

***Office Insurance policy**:* We will file your insurance, when possible, if we are unable to determine your insurance benefits prior to your first visit, the full session fee will be charged and you will be solely responsible for that fee. We further require some payment made your each visit, if you can not pay the full fee that visit we can send out a billing statement for the balance. If you have no insurance you and your therapist will have to come to an agreement on a workable payment plan. Your health care coverage is your responsibility to manage, if authorizations are require prior to your visits it is ultimately the clients' responsibility to assure those are secured or be full responsible for fees for services.

Primary Insurance Company Name	Secondary Insurance Company Name
Address City ST Zip	Address City ST Zip
Benefits Phone # Plan Name	Benefits Phone# Plan Name
Identification # & SS# Policy & Group #	Identification # & SS# Policy & Group #

I hereby assign all benefits otherwise payable to me to Associated Counseling Group, as payment towards the charges incurred for services rendered. I further instruct the insurance company named above to issue a check directly to Associated Counseling Group. I also authorize Associated Counseling Group to release any information pertinent to services rendered to any authorized representative of my insurance company, adjuster or review agency.

SIGNED BY:	**DATE:**

BILLING INFORMATION
If another individual or agency is responsible for payment, please complete the information below.

Billable Responsible Party Name			
Responsible Party Relationship to Client		Social Security #	
Address City State Zip Code			
Home Phone #	Work Phone #	Cell Phone #	Gender __M __F Date of Birth:
Employer		Percentage of Bill Responsible For:	