

# Dynamic Behavioral Consulting

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## HEALTH INSURANCE INFORMATION AND CONSENT

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Insurance Company Contact Numbers: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's DOB# \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Client's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Do you have secondary insurance? If so, please fill out the following:

Secondary Insurance Company: \_\_\_\_\_

Insurance Company Contact Numbers: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's DOB# \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Client's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

I authorize Dynamic Behavioral Consulting to obtain insurance benefits, submit claims, and receive payments of medical / mental health benefits on my behalf. By choosing to use my insurance for psychological services, my practitioner may be required to release certain information to the insurance company at their request. Information which may be requested includes types of services, dates / times of services, diagnosis, treatment plans, descriptions of impairment, progress of therapy, and at times case notes and summaries. If it is the case that my insurance company utilizes a managed care company, my practitioner / evaluator may need to discuss my treatment with a case manager. I understand that my confidentiality may be compromised in such as case. I realize that his / her doing so is a necessity in the efforts to secure ongoing care.

\_\_\_\_\_  
Client's name \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Insured's Signature (if different from patient) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_