# Dynamic Behavioral Consulting

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## HEALTH INSURANCE INFORMATION AND CONSENT: PAGE 1 OF 1

Client's Name: ________________________ Client's Ph: ( ) ____________ Client's DOB: ____________

Client's Address: ______________________________________________

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 Signature or Insured's Signature (if different from client) Date

______________________________________________

Parent / Guardian's Signature Date