

Soul Work Counseling

11108 Zeland Ave N, Suite 104, Champlin, MN 55316

Phone: 763-746-0842 Fax: 763-746-0843

New Client Insurance Verification

Patient Information

Patient Name _____

Age ____ Date of Birth _____ Gender ____ Marital Status _____

Home Address _____ Apartment# _____

City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Insurance Information

► *All information is required to obtain benefit information* ◀

Name of PRIMARY Insurance Co. _____ Insurance Phone (from back of card) _____

Group/Acct # _____ Member ID# _____

Policy Holder's: Name _____ DOB _____ Relationship to Pt. _____

Policy Holder's Employer (If insurance is obtained thru employer) _____

Does the patient have secondary insurance? ___ No ___ Yes If Yes, please complete page 2 for secondary insurance.

I assign all benefits from insurance or other third-party coverage to Soul Work Counseling. Further, I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Soul Work Counseling. A photocopy of this authorization may be honored.

Signature: _____ Date: _____

Benefit & Eligibility Information: To Be Completed by Office

Effective Date _____ % Covered _____ % Deductible \$ _____ Copay \$ _____

Amount paid towards deductible: _____ Group: 2:1 _____ 1:1 _____ Group Copay \$ _____

Max out of Pocket \$ _____ Max Payable by Insurance \$ _____

Verification by: Soul Work Counseling Rep _____ Ins Rep _____ Date _____ Private Pay Amount \$ _____

Private Pay Group \$ _____

No **Authorization** is required **Authorization #:** _____

Sessions: _____ Begin/End Date: _____

Send Claims to: _____