Destination Hope

NPI: 1750560637 BCBS: 7933LC

Client Information

***Date:*_____** ***First Appointment*: _____**

Client's Name: _____
First Middle Initial Last

Address: _____

City:_____ State: _____Zip: _____

Social Security #: _____ Date of Birth: _____ Email_____

Phone: (_____)_____ (_____)_____ (____)_____
Home Work Cell

Parent/Guardian Information *(if client is minor)**:***

Name:_____
First Middle Initial Last

Address (if different from client): _____

Social Security #_____ Date of Birth_____ Email: _____

Phone: (_____)_____ (_____)_____ (____)_____
Home Work Cell

Referred by: _____

Initial assessment: _____

Insurance Information

(Note: Please present insurance card with this form to be photocopied. Thank you.)

Name of Client: _____Date of Birth: _____/_____/_____

Name of Insured: _____**Date of Birth: _____/_____/_____**

Insurance Carrier: _____

ID#: _____ Group#: _____ *DSM:* _____

Benefit/Eligibility Phone Number: (____)_____ Co-pay: $_____

Effective Date of Policy: _____

Deductible: $_____ Amt of Deductible already met: $_____

Can Deductible be combined w/medical deductible? Y N Percentage paid by insurance: ____%

Visits per year: _____ Pre-certification required? Y N Authorization #: _____

If so, number of visits before calling again: _____

Payer ID# for electronic filing: _____

I authorize the release of any medical or other information necessary to process this claim.

_____
Insured's or Authorized Person's Signature

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.

_____
Insured's or Authorized Person's Signature