

Destination Hope Ministries
NPI: 1750560637

Client Information

Date: _____
Client's Name: _____
Street: _____
City: _____ State: _____ Zip: _____
SS #: _____ Birth Date: _____ E-Mail: _____
Home: _____ Work: _____ Cell: _____

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

Name: _____
Address: (if different from above) _____
City: _____ State: _____ Zip: _____
SS #: _____ Birth Date: _____ E-Mail: _____
Home: _____ Work: _____ Cell: _____

Insurance Information

For Magellan and Value Options Only.

Client's Name: _____ DOB: _____
Insured Name: _____ DOB: _____
Insurance Carrier: _____
ID #: _____ Group #: _____
Benefit/Eligibility Phone #: _____ Co-pay: \$ _____

I authorize the release of any medical or other information necessary for Destination Hope Ministries to process related insurance claims.

Signature of Insured or Authorized Person: _____

I authorize the payment of medical benefits to Destination Hope Ministries as the provider of services. I understand that I am responsible for all charges for services provided, not my insurance company. I further acknowledge that if my insurance company declines payment, I am responsible for the full amount of charges for services rendered by this counseling practice.

Signature of Insured or Authorized Person: _____