Family Guiding

Psychological Services, PLLC

INSURANCE INFORMATION AND CONSENT FORM

Client Information:

Name: _____ Date of Birth: _____

Insured's Information (if different from above):

Name: _____ Date of Birth: _____

Address (if different from client): _____

_____

Employer (if insurance plan is employment based): _____

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Insurance Information:

Plan: ☐ Empire Blue Cross/Blue Shield

☐ Empire Blue Cross/Blue Shield – Federal Employee Program

☐ Out of Network with the following insurance company: _____

Member ID Number: _____

Group ID Number: _____

I authorize Family Guiding Psychological Services, PLLC to release any records or information necessary to process each insurance claims for services rendered. I also authorize payment of medical and/or behavioral health benefits to my provider at Family Guiding Psychological Services, PLLC.

I understand that Family Guiding is an out of network provider for all insurance plans accept Empire Blue Cross Blue Shield. I understand that I am responsible for payment at the time services are rendered and will receive paperwork to submit for coverage through my out of network benefits.

_____

(Printed Name of Insured)

_____ _____

(Signature of Insured) (Date)