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505.804.1451

**Insurance Information and Release Form**

Client's Name: _____ Today's Date: _____

Policy Holder's SSN Number: _____Client's DOB: _____

This form must be completed if you want to use your insurance benefits for mental health treatment. A New You Counseling fee will be changed to the negotiated fees for these insurance companies only. If the services are not covered by the plan, then the fee will be changed back to the regular fee. These contracted insurance plans require that A New You Counseling submit the insurance forms directly to them. If you consent to use your coverage for this service, your insurance company will be allowed to have access of your medical records and mental health information.

1. Primary Insurance Company: _____

ID Number: _____ Group Number: _____ Co-Pay: _____

1. Policy Holder's Address: _____

City: _____ State: _____ Zip Code: _____

1. Name Policy Is Under (if other than yourself): _____

Their Date of Birth: _____

Relationship to Client: ( ) Spouse ( ) Parent/Child ( ) Other (specify)_____

**Release:** *I hereby grant permission for A New You Counseling to disclose information regarding this treatment to my insurance company, managed health care network and/or my employee assistance program. This may be done to assist in the management of the care and for the evaluation and administration of my claims, as appropriate.*

**Assignments:** *I authorize payment of medical benefits to be made directly to A New You Counseling for services rendered.*

**Responsibility:** *I understand that I am responsible for the co- payment amount and any deductible amount. I understand that if I do not provide the correct information for insurance*

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*billing, (including proper authorizations required by your plan) I will be responsible in full for services rendered at A New You Counseling regular rate. If, for any reason, the insurance company denies the request for payment or the services are not covered or paid for by my insurance company, I agree to make arrangements for prompt payment for services rendered. I am aware that insurance companies do not provide reimbursement for canceled sessions. I will be responsible for any appointment for which I do not show, or have not canceled within 24 hours.*

Signature: _____ Date: _____