

**FAMILY CHRISTIAN COUNSELING
INSURANCE BENEFITS VERIFICATION FORM**
Physician Insurance Benefit Inquiry

OUR POLICY ON INSURANCE

We offer the service to you to submit claims on your behalf to your insurance carrier. However, **YOU ARE FINANCIALLY RESPONSIBLE TO US FOR YOUR BILL.** Your insurance carrier or third party payer is responsible only to YOU, not to us. Until coverage is verified, we ask that you pay for counseling services at the end of each session. We will notify you once we confirm the amount of coverage available from your insurance company. Along with the following information, we will need you to present your insurance card. We will make every effort to work with your insurance company.

PRIMARY _____ SECONDARY _____

Patient's Name _____ Date of Birth _____

Address _____

Patient's status: (circle) Married Single Employed Student-Full/Part Time

Subscriber's Name _____ Date of Birth _____

Insurance Company Name _____

Telephone # for claims/benefits _____

Subscriber # or Social Security # _____

Group/Policy/Certificate # _____

Subscriber's Employer _____

I authorize the release of any medical or other information necessary to process my claims. I authorize Family Christian Counseling to file claims on my behalf, and I assign payment to Family Christian Counseling for those claims.

INSURED OR AUTHORIZED PERSON'S SIGNATURE

DATE

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