A NEW DAY COUNSELING CENTER
Western Seminary
5511 SE Hawthorne Blvd.
Portland, OR 97215
Phone: 786-A-NEW-DAY Fax: 503-517-1927

Attach a copy of the front and back of your insurance card

Release of Information for Health Insurance

If you choose to use insurance to cover a portion of your treatment costs, you will be waiving your right to confidentiality. Insurance companies often require counselors to submit extensive client information, including but not limited to diagnosis, type of treatment, dates, copies of chart notes, justification for treatment, progress reports, and financial information. Once information is released to an insurance company, our organization has no control over who is able to access the information. If at any time you elect not to release information, you will be assuming the financial responsibility for your treatment.

We prefer payment at the time of service. We are willing to bill your insurance company for services rendered. Since not all individuals can afford to pay the full fee at the time of service, we offer the alternative of paying only the anticipated amount of co-payment for each session. If an insurance payment results in a credit balance, we will promptly issue a refund check to you.

You have the final responsibility for payment of services, even when insurance is billed on your behalf. By completing the requested information and signing the authorization below, you are assuming financial responsibility for your account, waiving confidentiality, and giving us permission to bill the insurance company on your behalf.

1a. Insurance Identification Number: _____.

2. Client Name: _____.
Last, First, Middle

3. Client Date of Birth: _____ 3. Male or Female

5. Client address: _____.

Client phone number: _____.

8. Client status: Single Married Other _____.
Employed Full-time Student Part-time Student

4. Name of Insured: _____.
Last, First, Middle

6. Relationship to insured: Self Spouse Child Other .

7. Insured address: _____.

Insured phone number: ( ) _____.

(Please continue on other side of page)

11. Insured's Policy Number: .

11a. Insured's Date of Birth: Male or Female

11b. Insured's Employer or School: .

11c. Insurance Company Name: .

11d. Is there a secondary insurance plan (listed below)? yes or no

Primary Insurance Billing Address and Phone Number: .

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9. Name of Other Insured: .
Last, First, Middle

9a. Other Policy Number: .

9b. Other Insured's Date of Birth: Male or Female

9c. Other Insured's Employer: .

9d. Other Insurance Company Name: .

Company Billing Address: .

10. Is Client's condition related to Employment: yes or no
Auto Accident: yes or no Other Accident: yes or no
Dates of related employment/accident: .

I/We hereby authorize the release of any medical, mental health, or other information necessary to process insurance claims. I also request payment of benefits be sent to A New Day Counseling Center. I hereby grant permission to A New Day Counseling Center to bill my insurance company in the future without me having to sign for this each visit.

I/We understand that I am responsible for any charges not covered or reimbursed by my insurer. Also, I understand that this authorization is valid until withdrawn by me in writing, and that I may revoke this release at any time except to the extent that action has already been taken consistent with my prior consent.

I/We acknowledge that I have been provided information regarding confidentiality, office policies, including fees, policies regarding missed appointments and late cancellations, the right to refuse treatment, and professional information about my counselor in a separate Disclosure Statement.

Dated: Signed: .

Dated: Signed: .