CLIENT INSURANCE VERIFICATION FORM

First Name:_____ **Last Name:**_____ **Middle Initial:** _____

Address:_____ **City:**_____ **St:**_____ **Zip:** _____

Home Telephone #:_____ **Alternate Telephone #:** _____

Date of Birth:_____/_____/_____ **Social Security No.:**_____-_____-_____ **Sex:** _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other:_____ **Age:** _____

Responsible Party:_____ **Email address:** _____

Relationship to client:_____ **Occupation:**_____ **Work Telephone:** _____

Employer:_____ **Email:** _____

Client's Spouse or Parent (If Minor):_____ **Telephone #:** _____

Emergency Contact:_____ **Telephone #:** _____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Michael Chambless, LLC for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize Clear Solutions, LLC (contracted billing service for Michael Chambless, LLC) to file a claim for these services (and to refile as necessary to collect) with the client's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize Clear Solutions, LLC to sign said claim(s) or any refiled claim on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name:_____ **Signature:**_____ **Date:** _____

Insurance Information

Company Name:_____ **Telephone #:**_____ **Policy No.:** _____

Group No.:_____ **Policy Holder's Social Security No. (if different from Client):**_____-_____-_____

Policy Holder (if different from Patient): **Relationship:** _____

TO BE COMPLETED BY BILLING OFFICE

Date:_____ **Spoke with:**_____ **Circle one:** **In Network** **Out of Network**

Policy Effective:_____ **Co pay Per Visit: $**_____ **Coinsurance Per Visit:** _____

Deductible Amount: $_____ **Deductible Met: $**_____ **Max Visits/Max Payable Per Year:** _____

Out of Pocket Max Per Year:_____ **Exclusions to policy:** _____

Claims Address:_____ **City:**_____ **St:**_____ **Zip:**_____

Authorization #:_____ **Sessions Approved:**_____ **Authorization Date:**_____ **thru** _____

Notes: _____