
## INSURED/RESPONSIBLE PARTY INFORMATION

**Please complete this section regardless of insurance coverage.**

Full Name of Insured:_____ Date of Birth: _____ Relationship to insured: _____

Occupation: _____

Home Address:_____ City:_____ State:_____ Zip:_____

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____ Ext. _____

Employer Name and Address:_____ _____

Insured's SS# _____-_____-_____ Driver's License No. _____ State _____

Spouse's Employer: _____ Phone ( ) _____

Insured's Primary Ins. Co. _____ I.D. No. _____ Policy No. _____

Insurance Authorization No._____ EAP Authorization No. _____

**Number of Approved EAP Sessions: _____**

**** EAP CLIENTS ONLY****

Employee Name _____ Date of Birth _____S.S.# _____/_____/_____

Company _____ Company Address _____

Job Title _____ Department _____

Exempt _____ Non-Exempt _____ Years at Company _____ Union Member _____

Salary Range (Please circle one) less than $10,000 $10,000-$20,000 $21,000-$35,000 $36,000-$50,000 $50,000+

Supervisor _____ Phone #: ( ) _____

**OFFICE BILLING AND INSURANCE POLICY**

1. I authorize the release of information to my insurance company(s).
2. I understand that I am responsible for full amount of my bill for services provided.
3. I authorize direct payment to my service provider.
4. I authorize use of this form on all of my insurance submissions.
5. I hereby permit a copy of this form to be used in place of an original.
6. It understand that it is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance the day and time service is provided.
7. There will be a $35.00 service charge on all returned checks.
8. In the event that your account goes to collections, there will be a 20% collection fee added to your balance.
9. I understand that there is a charge of $65.00 for cancellations with less than 24-hours notice or no-show appointments. Cancellations must be made during regular office hours, between 9:00 AM and 5:00 PM Monday through Friday.
10. I understand that all services rendered by Calvary Counseling Center are final and non-refundable.

Client/Responsible Party's Signature_____ Date _____