Ray Hopkins, LMHC
Hopkins Counseling Services, LTD
Please fill form out legibly and completely to avoid delay in insurance billing.

Patient

Name ______________________________ Male / Female

Address ______________________________
Street City State Zip

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Birthdate ____________ Age ________ Married Single Other

Billing Information

Responsible Party ______________________ Relation to Patient: Self Spouse Child Other

Address ______________________________
Street City State Zip

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Birthdate __________ Age _____ Married Single Other Email: ____________

Who referred you to this office? ______________________________

Insurance Company ______________________________

Insurance Billing Address *(or copy of front and back of card)* ______________________________

____

Insurance Phone Number ____________________ Contact Person ____________________

Subscriber ID (or Claim #) ____________________ Group #: ____________________

Name & address of any additional person you authorize this office to communicate with regarding your account:

____

Date of Injury ____________ **Work Related?** Yes / No **Auto Accident ?** Yes / No

Diagnosis (*provider use only*) ____________ **Referring Physician** ____________

I state that I have insurance as noted above and assign all benefits payable directly to PROVIDER. I understand that my insurance company is billed as a courtesy to me and agree by signing below to pay the charges in full in the event of non-payment by my insurance company within 60 days of billing. I understand that it is my responsibility to meet any referral requirements of my insurance plan and that I will be responsible for payment if claims are denied due to violation of referral policy. I authorize PROVIDER and BILLING SERVICE to release all information necessary (including chart notes) to my insurance company to secure payment of benefits.

Signature ______________________________ **Date** ____________

Office Use Only: ______ Pt Info Form ______ Copy of Insurance Card ______ Dx