FREEDOM COUNSELING CENTER INC.
1901 Niles Ave, Ste 102
Saint Joseph, MI 49085
(269) 982-7200 Fax (269) 982-0202

INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with:

_____ _____
Name of Primary Insurance Company and/or Name of Secondary Insurance Company

and assign directly to Freedom Counseling Center, Inc. all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance. Please be advised that we do not accept Medicaid HMO as a secondary insurance.

The above named institution may use my health care information & may disclose such information to the above named Insurance Company(ies) & their agents for the purpose of obtaining payment for services & determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Insurance Company: _____ Phone: _____

Insurance Co. Address: _____ Zip Code: _____

Name of Insured: _____ Insured SS#: _____

Insured Birth Date: _____ Insured Employer: _____

Insured Address: _____ City/State/Zip: _____

_____ _____
Signature of Patient, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Guardian or Personal Representative **Relationship to Patient**

Medicare/Medigap Authorization

Patient's Name: _____ Date of Birth: _____

Medicare Number: _____ Patient ID No.: _____

I request that payment of all authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to:

_____
Name of Doctor, Clinic, Healthcare Provider or Supplier

For any services furnished to me by the provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to relase to the Center for Medicare Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

_____ _____
Signature of Patient, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Guardian or Personal Representative **Relationship to Patient**

RESET PRINT