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: _____

Name of Secondary Insurance Company (if applicable): _____

I 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 and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and 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 Primary Insured: _____

Primary Insured SS#: _____

Primary Insured Birth Date: _____

Primary Insured Employer: _____

Primary Insured Home Address: _____

City/State/Zip: _____

_____

Signature of Patient, or Guardian

_____

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