**Insurance Information & Consent**

PRIMARY INSURANCE INFORMATION (Please complete information for policy holder)

Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement

* I authorize Beverly M. Davis, Ph.D. to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf.
* This authorization extends to the extent necessary to obtain payment for the services provided to me and to release information about mental health.
* In consideration of the services provided to me, I assign all benefits to Beverly M. Davis, Ph.D. if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Beverly M. Davis, Ph.D. and its affiliates.
* I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.
* If I want to use insurance, I authorize Dr. Beverly Davis to file for my insurance and to accept assignment of insurance payment for her services unless otherwise specified above
* I understand that if I use insurance, Dr. Beverly Davis may be required to communicate with representatives of my insurance carrier.
* If my insurance company or managed care company does not cover services. I realize that I am responsible for all fees for services provided

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_