INSURANCE INFORMATION FORM

Release of Information & Assignment of Benefits

I understand and agree to the following:

I authorize the release of information from my medical record to the insurance company or other third-party payer named above. This information shall include all information necessary to submit and process claims, such as my name, date of birth, address, medical diagnosis, and services provided to me.

If the practice has already shared information with the insurance company or other third-party payer at the time I revoke this authorization, it is too late to prevent that information from being shared.

This authorization is necessary for the practice to determine eligibility for treatments or benefits or to pay for treatments I receive, but the practice cannot condition treatment on the provision of this authorization.

This authorization shall be continuously effective from the date of my signature, unless I contact the practice in writing any time prior to then to revoke.

In consideration of the services provided to me, I assign all benefits to the practice, if accepted, and authorize this insurance company to make payments directly to the practice and its affiliates on my behalf.

Acknowledgement

I authorize Coastal Virginia Counseling 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 includes authorization to release information about mental health, substance use, or diagnoses as required. In consideration of the services provided to me, I assign all benefits to Coastal Virginia Counseling if accepted, and authorize my insurance companies, or other third-party payers to make payments directly to Coastal Virginia Counseling 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. I understand that if I am using Tricare insurance, Coastal Virginia Counseling is out of network with Tricare, and an authorization is needed for Tricare Prime. I understand that Coastal Virginia Counseling does not take Cigna, Virginia Premier, or Medicare. I understand that Coastal Virginia Counseling does NOT accept secondary insurance. I understand my full insurance benefits, and have called my insurance to confirm these benefits before the appointment.

X Signature_____

Insurance Company:_____

Member/Beneficiary ID:_____

Policy Group:_____

Plan Name:_____

Policy Holder Name and Date of Birth and address:_____

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