Behavioral Care Services — Psychological Evaluations, Therapy & Consultation
Children, Young Adults, Adults & Families

Signature on File and Assignment of Benefits Agreement (for insurance patients)

PATIENT INFORMATION

Name of person completing the form_____
Last First

Relationship to the Client_____

Client's Name_____
Last First Middle Initial

Age_____ Date of Birth ___/____/____Place of Birth_____
(mm/dd/yyyy) City/US State/Country

Home Street Address_____

City
_____State_____Zip_____

Home Phone Number_____ Alternate Phone Number_____

PRIMARY INSURANCE

Person responsible for account _____
Last First Middle Initial

Relationship to Patient_____ Date of Birth ___/____/____SSN_____
(mm/dd/yyyy)

Address_____
(if different than patient's)

City _____State_____ Zip_____

Subscriber Employed By _____

Employer's Address_____

City _____State_____ Zip_____

Insurance Co._____ Group #_____Member #_____

7340, Heritage Village Plaza, Suite 102, Gainesville, VA 20155
Phone: 7033981085, Fax: 1-866-299-2424

SECONDARY INSURANCE

Is patient covered by additional insurance? _____ Yes____ No

Subscriber's Name_____ _____
Last First Middle Initial

Relationship to Patient_____ Date of Birth ___/____/____SSN_____
(mm/dd/yyyy)

Address_____
(if different than patient's)

City _____State_____ Zip_____

Subscriber Employed By _____

Employer's Address_____

City _____State_____ Zip_____

Insurance Co._____ Group #_____Member #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ _____ I understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and copayments, in addition to payment for any services of treatment not covered by my insurance carrier. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Behavioral Care Services. I authorized the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to Behavioral Care Services of the insurance benefits otherwise payable to me for all professional services.

Patient/Parent/Guardian Signature_____

Printed Name: _____Date: _____

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