



[www.insightsooutside.com](http://www.insightsooutside.com) ~ 503.730.8903 ~ [teresa@insightsooutside.com](mailto:teresa@insightsooutside.com)

### **Insurance Information**

Please skip this portion if paying out of pocket

Insurance Provider: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Primary Insured Person on your policy \_\_\_\_\_

Primary Insured's employer \_\_\_\_\_

Primary Insured's address \_\_\_\_\_

(if different from your own) \_\_\_\_\_

Primary Insured's Phone #: \_\_\_\_\_

Primary Insured's date of birth \_\_\_\_\_

### **AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS – See also “Consent to use and disclose your health info”**

- I hereby authorize the provider to furnish my insurance company with all information requested concerning my present claim.
- I acknowledge that I am responsible for the payment of all charges up front (Lifewise and First Choice excluded) and that reimbursement checks will be sent directly to me via the insurance company.
- I agree to pay in full for services leading to written reports prior to their release.
- I authorize payment of benefits from my insurance provider to Teresa Field, LPC, LMFT

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

Printed Name \_\_\_\_\_

Today's Date \_\_\_\_\_