

# Dipoto Counseling Group

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*Patient Name:* \_\_\_\_\_

**Circle the appropriate third party payer:**

**EAP**

**Insurance**

**Tricounty**

**Other**

**Primary Insured's Information:**

Name: \_\_\_\_\_ Relation to client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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

Address for Claims: \_\_\_\_\_

Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Is there another Insurance Provider?** Yes  No  *If so, please list additional insurance information:*

Insurance Provider: \_\_\_\_\_ Primary Insured's Name: \_\_\_\_\_

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

**Authorization for release of information for billing purposes:**

I hereby authorize the release of any information necessary for third-party claim submission and/or payment for services. I authorize payment of third-party benefits to *Dipoto Counseling Group* for services described herein. ***I understand that I am responsible to pay for all sessions, including No Show appointments. A No Show appointment is a cancellation with less than 24 hours notice. Most insurance providers will not pay for No Show appointments; therefore it is the sole responsibility of the insured to pay for No Show appointments.***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Your Full Name

\_\_\_\_\_  
Date of Birth