PERSONAL INFORMATION
AND INSURANCE FORM

Daniel Pryor, MA LMHC
Professional Counseling
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Client's Name (include middle initial): ______________________________ DOB: ________ Sex: _____

Home #: _____________ Cell #: _____________ Work #: ____________ (Accept calls at work? Yes /No)

Email Address: ____________________________ Best way to contact you: ________________________

Home Address: ____

Occupation: ______________________ Employer: _________________________ How long: __________

Your reason for seeking counseling: ____

In Case of emergency contact: __________________________________Phone______________________

Would you like to receive periodic informational mailings? Yes/No

Insurance Information

Insured's Name: __________________________________ Insured's DOB: ____________________________

Insured's Employer: ____

Name of Mental Health Benefits Insurance Carrier: ____

Policy number: ____________________________ Insured's ID Number: ______________________________

Group ID Number: _______________ Insurance Company phone number: ______________________________

Insurance company's address: ____

Is there another mental health benefits plan? ____

Mental Health Benefit (questions to ask your insurance company)

1. Is Licensed Mental Health Counselor (LMHC) in Washington on the approved list of providers? ________________
2. Out patient counseling coverage: ____
3. Percent coverage: ________________ Deductible: __________ How much has been met? ______________
4. Is precertification required? ___________________
5. Maximum payable per year: ______________ Max visits/year? _______ Max visits/week? _______
6. Person Contacted: ____
7. Address for filing claims: ____
8. In network coverage_________________ Out of network coverage _________________________________
9. Special instructions for filing claims: ____

Assignment of Insurance benefits

By signing this form I am voluntarily authorizing the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes ______________________________ to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each particular claim.

I, _________________________, hereby authorize ____
(Name of insured) (Name of Insurance Company)
to pay and hereby assign directly to _____________________________, all benefits, if any, otherwise payable to me for her services as described on this form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to ______________________________, will be credited to my account in accordance with the above said assignment.

Insured's Signature: __________________________________ Date ________________________________

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