Client Information Sheet for Medical Billing
Kelly Benjamin, LPC

Please complete this form **COMPLETELY**

Date: _____

Client Name (Formal Name):_____

Date of Birth: _____ Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Other

Address: _____ City, State, Zip Code _____

Email Address_____

Phone Number: Home (_____) _____ Cell (_____) _____ Work (_____) _____

Employment: _____

Insurance Information-PLEASE FILL OUT ALL INFORMATION COMPLETELY

Primary Insured Name (Formal Name) _____Date of Birth_____

Address if different then above_____

Phone Number of Primary Insured_____ SS# of Primary Insured_____

Email Address of Primary Insured_____ Sex: ☐Male or ☐Female

Marital Status of Primary Insured: ☐Married ☐Single ☐Other

Insurance Company Name_____ Member ID #_____

Customer Service Phone Number (Back of Card) _____

Name of employer: _____ Who is financially responsible for this bill?_____

Do you have secondary insurance coverage?? ☐YES ☐NO

Please Fill Out Page 2-Secondary Insurance Information

Release of Information for Insurance Verification/Authorization of Benefits /Claims Processing/Fee/Payment
Please initial below

_____I authorize Kelly Benjamin and its subsidiaries, to check/verify insurance coverage and benefits.
_____I authorize the release of any medical or other information necessary to process claims related to services provided by Kelly Benjamin.
____I authorize payment of medical benefits to Kelly Benjamin for services provided.
____I understand and agree that I am financially responsible to pay for co-pay/coinsurance/deductible/other services not covered by my insurance. I assign all benefits from insurance or other third-party coverage to Kelly Benjamin. Further, I understand that by signing this form I acknowledge that if my insurance carrier or HMP/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Kelly Benjamin.

Client Signature or Authorized Person's Signature_____ Date _____

For Therapist only:

All Diagnosis Codes: _____