Alliance Counseling
Jean Allbee-Roberson LMFT LLC
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Release of Information and Assignment of Benefits for Insurance Companies

Client Name: _____ Client DOB: _____

Client Address: _____

Contact Phone #: _____ Contact E-mail: _____

Person Financially Responsible (if a minor): _____

Emergency Contact: _____ Phone number: _____

Primary Insurance: _____ Plan Provider Phone #: _____

ID#: _____ Group #: _____

Insurance Subscriber: _____ Subscriber DOB: _____

Relationship to Client: _____ Subscriber SSN #: _____

Subscriber Address: _____

Secondary Insurance: _____ Plan Provider Phone #: _____

ID#: _____ Group #: _____

Insurance Subscriber: _____ Subscriber DOB: _____

Relationship to Client: _____ Subscriber SSN #: _____

Subscriber Address: _____

___ I authorize the release of any medical or other information (including psychiatric, HIV, and drug and/or alcohol related) necessary to process my claims. I also request payment of government benefits either to myself or the party who accepts the assignment.

_____

Client or Authorized Person's Signature Date

___ I authorize payment of medical benefits to the assigned physician, provider, or supplier for services provided through Jean Allbee-Roberson LMFT LLC.

_____

Client or Authorized Person's Signature Date