

# Your Family Matters

6300 117th Ave. N., Champlin, MN 55316

Phone: 763-458-0154 Fax: 763-427-5688

## New Client Insurance Verification

**Patient Information (If possible complete & FAX this form before the first session)**

Patient Name \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email address: \_\_\_\_\_

### Insurance Information

▶ All information is required to obtain benefit information •

Name of PRIMARY Insurance Co. \_\_\_\_\_ Insurance Phone (from back of card) \_\_\_\_\_

Group/Acct# \_\_\_\_\_ Member ID# \_\_\_\_\_

Policy Holder's: Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_

Policy Holder's Employer (If insurance is obtained thru employer) \_\_\_\_\_

Does the patient have secondary insurance? No \_\_\_ Yes \_\_\_ If Yes, Secondary Ins. Co. \_\_\_\_\_  
Ins. Phone (back of card) \_\_\_\_\_ Grp # \_\_\_\_\_ ID# \_\_\_\_\_

I assign all benefits from insurance or other third-party coverage to Your Family Matters. Further, I understand that by signing this form I acknowledge that if my insurance carrier or HMO/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 Your Family Matters. A photocopy of this authorization may be honored.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Benefit & Eligibility Information: To Be Completed by Office

Effective Date \_\_\_\_\_ % Covered \_\_\_\_\_ % Deductible \$ \_\_\_\_\_ Copay \$ \_\_\_\_\_

Amount paid towards deductible: \_\_\_\_\_ G 1 : 1 \_\_\_\_\_ Group Copay \$ \_\_\_\_\_

Max out of Pocket \$ \_\_\_\_\_ Max Payable by Insurance \$ \_\_\_\_\_

No Authorization is required Authorization #: \_\_\_\_\_

# Sessions: \_\_\_\_\_ Begin/End Date: \_\_\_\_\_

Coverage for Marriage  Coverage for Family