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 AND both sides of your INSURANCE CARD before the first session) PLEASE PRINT CLEARLY!!!!!

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 •

IS THIS INSURANCE WITH MEDICARE? _____________

Name of PRIMARY
Insurance Co. ___________________________________Insurance Phone (from back of card) ___________________

Group/Acct#______________________________ MemberID#____

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 ☐