MENTAL HEALTH SOLUTIONS S.C.

NEW CLIENT INSURANCE INFORMATION

Please Provide Us with the Current Insurance Card(s)

PRIMARY INSURANCE

Insurance Company: _____

Policy Holder: _____

Date of Birth: _____

Address: _____

City/State/Zip_____

Client Relationship to Policy Holder:

_____

SECONDARY INSURANCE

Insurance Company: _____

Policy Holder: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Client Relationship to Policy Holder:

_____

DOES YOUR INSURANCE COMPANY REQUIRE PRIOR AUTHORIZATION FOR SERVICES?

YES___ NO___

If Prior Authorization is Required and the Client or Client's Agent Fails to Contact the Insurance Provider to Obtain the Authorization, the Client Accepts Full Financial Responsibility for Any and All Charges.

I hereby attest that the above provided information is accurate. I agree to obtain any prior authorization(s) needed by my insurance(s). I authorize insurance(s) to make payments directly to: Mental Health Solutions, S.C.. I also authorize the release of any medical information necessary to process my insurance claims if applicable.

Signature of Client (14 and Older):_____ Date: _____

Printed Name of Authorized Person: _____

Signature of Authorized Person: _____ Date: _____

If signed by a person other than the patient, stated authority to do so (Circle one):

Legal Authority Legal Guardian Next of Kin Parent of Minor Power of Attorney