Reflective Counseling Services

Helping you achieve your mental and emotional wellness goals

Patient Information

Last Name_____ First _____MI_____

Address_____City_____

State_____Zip_____ Cell Phone_____

Ok to leave phone message? Yes/No Gender as enrolled with insurance company: Female/Male

Date of Birth_____Age_____ Preferred Pronouns:_____

Race: ___Asian ____ American/Alaskan Indian ____ Black/African American ____ Hawaiian ____Caucasian

____Other ____Declined Ethnicity: _____Hispanic / Latino _____Non Hispanic /Non Latino

Emergency Contact:_____Number:_____Relation:_____

Guarantor Information

LEGAL GUARDIAN, OR WHOMEVER BRINGS IN MINOR CHILD OR INCAPACITATED ADULT, MUST COMPLETE THIS SECTION

Last Name_____ First _____MI_____

Address_____City_____

State_____Zip_____ Cell Phone_____

Ok to leave phone message? Yes/No Ok to text message? Yes/No Date of Birth_____Age_____

Primary Insurance Holder Information

Last Name_____ First _____MI_____

Address_____City_____

State_____Zip_____ Cell Phone_____

Date of Birth_____Gender_____Relationship to primary: Spouse/Child/Self/Partner

5589 East M-36 Suite B-8
Pinckney, MI 48169

P: 810.207.1439
F: 810.355.1138

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third-party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient OR Guarantor Signature (if patient is a minor or incapacitated adult)

_____Date_____

Medicare Authorization and Assignment of Benefits: (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature_____ Date_____

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