Addiction & Mental Health Counseling of San Diego
Client Insurance Information

Name: _____

Date of Birth: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone: _____

(Please only list number where we can contact you or leave a message.)

Insurance Information

Insurance Company Name: _____

Name of Primary Insured (if different): _____

Date of Birth (if different): _____

Insurance ID #: _____

Relationship to Insured: _____

Affirmation of Understanding

I verify that the insurance information is correct as of the date below. I understand that if I do not provide accurate information or if my insurance company does not cover my services, I will be responsible for full payment of these mental health services. I authorize Addiction & Mental Health Counseling of San Diego to file claims to my insurance company. I also authorize Addiction & Mental Health Counseling of San Diego to release medical information (e.g., diagnosis, treatment) necessary to process my claims. Finally, I authorize the insurance company to pay Addiction & Mental Health Counseling of San Diego directly for my services.

Signature of Client or Guardian of Minor:_____ Date: _____