Abundance of Hope
Counseling Services

1301 Northwest Highway Suite 209 Garland, Texas 75041 214-501-3667

HEALTH INSURANCE INFORMATION

Please call the phone number(s) on your health insurance card to get the following information PRIOR to your first session and bring this form with you. PLEASE OBTAIN ANSWERS TO ALL QUESTIONS TO INSURE THE BEST RESPONSE FROM YOUR INSURANCE COMPANY.
Thank you

Name:_____Date of birth:_____

Insured's name: (Mark "SAME" if you are the insured)_____

SS # of Insured:_____

Name of insurance company:_____

Insured's Employer & Group Number:_____

Name of the group that handles the Mental Health portion of your health insurance (It's often different):_____

Address for Mental Health claims:_____
(This is frequently different than the Medical claims address on your card)

Effective Date:_____ Phone(s):_____

ADDITIONAL IMPORTANT QUESTIONS TO ASK YOUR INSURANCE COMPANY:
1. Do I have mental health out-patient benefits? YES NO (If not, STOP HERE)

2. If so, do I have a separate mental health deductible? YES NO
If applicable, how much of that deductible have I met? N/A OR $

3. Is prior authorization needed for counseling? YES NO
If "YES," ask for authorization **NOW**, indicating which family member is the client

4. If so, do I need to see a counselor/ therapist on your list? YES NO
Is the counselor I want to see (give name) on your list? YES NO
If not, do I have any "out of network" benefits? YES NO

5. If applicable, what is my authorization number?

6. If applicable, how many sessions are authorized?

7. For what dates are those sessions authorized?
8. If applicable, what is my co-payment for mental health? $ Per session

9. How many sessions are allowed per calendar year? When does my calendar year begin and end?

WRITE ANY OTHER DETAILED INFORMATION ON THE BACK OF THIS FORM

Chikeitha Owens M.A, LPC, LCDC

HEALTH INSURANCE AUTHORIZATION FOR FILING CLAIMS
I authorize the release of any medical or other information necessary to process insurance claims on my behalf, or on behalf of the named minor for whom I am legal parent or guardian, by the above named provider.

_____

Patient (parent/guardian) Signature Date
Minor for whom services are being provided, if applicable

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I authorize payment of medical benefits to the above named provider for services rendered.

_____

Patient (parent/guardian) Signature