Mimosa Christian Counseling Center, Inc
220 Burkemont Avenue
Morganton, NC 28655

INSURANCE AUTHORIZATION AND REIMBURSEMENT

Client Name: _____ Record # _____

Date of Birth:_____ Medicaid # if applicable: _____

Please complete the following information only if you wish for your Primary Insurance Carrier to be billed for services. You should be aware that your contract with your Insurance Carrier requires that your counselor provide information relevant to the services provided. Mimosa staff will be required by your Carrier to provide a clinical diagnosis and possibly additional clinical information, such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, Mimosa staff will make every effort to release only the minimum necessary information for the purpose requested. This information will become part of the Carrier's files. At that point, Mimosa Christian Counseling Center, Inc. has no control over what the insurance company does with such information. You have the right to pay for services yourself to avoid any potential problems with your Carrier having such information.

Please give insurance card to receptionist to copy.

Primary Insurance Carrier: _____
Policy #: _____ Group #: _____
Client Date of Birth: _____ Client Social Security #: _____
Subscriber's Name: _____ Subscriber's Date of Birth _____
Relationship to Subscriber: _____ Subscriber's Social Security #: _____
Subscriber's Address if different from client's _____
_____
Subscriber's Telephone Number if different from client's _____
Subscriber's Employer/School _____

Secondary Insurance Carrier (if applicable): _____
Policy #: _____ Group #: _____
Subscriber's Name: _____ Subscriber's Date of Birth _____
Relationship to Subscriber: _____ Subscriber's Social Security #: _____

I hereby authorize Mimosa Christian Counseling Center, Inc. to disclose the minimum necessary information to the above listed Insurance Carrier(s). The purpose of this disclosure is to obtain benefits information, authorization for treatment, and to facilitate billing and revenue collection for all services provided from my first date of service. I understand that this authorization for financial transactions is valid indefinitely. I understand that I am personally responsible for the costs of services including but not limited to any unmet deductible, co-payment, and fees or portions of fees not paid by my Carrier.

Signature of Client / Legal Guardian or Responsible Party Date

Witness Date