LAKE GENEVA WELLNESS CLINIC, LLC

Ph: 262-248-7942 Fax: 262-248-1202

BILLING-INSURANCE INFORMATION FORM

IF USING INSURANCE PLEASE COMPLETE THIS SECTION *If you have additional insurance, please list on a separate sheet.* As a courtesy, we will file for reimbursement with the insurance company; however, the ultimate responsibility for payment on the account is the client's or the client's parent/guardian. The Lake Geneva Wellness Clinic, LLC does not accept responsibility for collection of any claim or negotiating a settlement on a disputed claim. The client will receive a statement if there is an outstanding balance or upon request. In the event the client or client's parent/guardian does not pay an outstanding balance, the client's accounts may be referred to a collection agency, which could lead to legal action.

Primary Insurance Company_____ Insurance Company Phone#_____

Insurance Company Address_____ City_____ State_____ Zip_____

Member ID #_____ Group #_____ Circle Coverage:Family/Individual

Name of Policy Holder_____ Relationship to Client_____

Secondary Insurance Company_____ Insurance Company Phone #_____

Insurance Company Address_____ City_____ State_____ Zip_____

Member ID #_____ Group #_____ Circle Coverage: Family/Individual

Name of Policy Holder_____ Relationship to Client_____

Please present your photo ID and Insurance card for copying

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make payments directly to Lake Geneva Wellness Clinic, LLC for therapy services. I accept personal responsibility for the deductible amount, copays, and for any balance outstanding after payment of such benefits. I further understand that copies of this authorization will be used in subsequent billings and will be accepted as valid as the original.

Client (or parent/guardian)_____ Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand I am under no obligation to sign below and Lake Geneva Wellness Clinic, LLC who I am authorizing to use and/or disclose my health information may not condition treatment or payment on my decision whether to sign this authorization. I authorize release of claim form information to all my insurance companies. I authorize release of treatment reports (written and/or verbal) as requested by my insurance company or managed care organization. I authorize use of this authorization on all my insurance submissions. I permit this signed authorization to be used in place of the original. I understand I have the right to revoke this authorization at any time. I also understand my revocation of this authorization must be in writing. I am aware my revocation will not be effective if: (1) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or, (2) to the extent the treating therapist and/or Lake Geneva Wellness Clinic, LLC has already acted in reliance upon this authorization.

Name of Policy holder:_____ Member ID/Group number:_____ Client (or parent/guardian)_____ Date_____