Stoner
COUNSELING SERVICES LLC

Bill Stoner, MA, LMHC
Psychotherapy, Clinical Supervisor, CSAT

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StonerCounseling.com

Client Billing Information Required for Insurance Coverage

The following information is required from you (my client) and from the person who has insurance coverage (the policy holder) in order for Stoner Counseling Services, LLC and for Phoenix Offices, LLC to request authorization for treatment and to obtain payment from the insurance company.

Client Information

NAME Legal Name (First, Middle Initial, Last)			
BIRTH DATE (mm/dd/yyyy)	**SOCIAL SECURITY NUMBER**		
MAILING ADDRESS	City	State	Zip
PHONE Home or Cell Phone (circle which one)	**PHONE** Work		
EMPLOYER	**PRIMARY CARE PHYSICIAN** Name		

Insurance Information

LEGAL NAME OF POLICY HOLDER (First, Middle Initial, Last)	**CHECK HERE IF SAME AS CLIENT** ☐		
POLICY HOLDER'S SOCIAL SECURITY NUMBER	**BIRTH DATE** (mm/dd/yyyy)		
POLICY HOLDER'S ADDRESS	City	State	Zip
POLICY HOLDER'S EMPLOYER			
INSURANCE PLAN NAME	**NUMBER**		
INSURANCE PLAN ADDRESS	City	State	Zip
GROUP NUMBER	**PHONE** Insurance		
CO-PAY	**DEDUCTIBLE**		

Secondary Insurance (to be completed if you have additional insurance)

INSURANCE PLAN	**NUMBER**		
ADDRESS	City	State	Zip
POLICY HOLDER NAME	**BIRTH DATE** (mm/dd/yyyy)		

Client Information

Check and initial each statement, then sign below:

☐ I authorize my insurance company to send payments directly to Stoner Counseling Services, LLC, and or William (Bill) Stoner, MA, LMHC for services rendered.

Your initials:

☐ I accept full responsibility independent of my insurance and agree to pay all co-payments, deductibles, and balances due.

Your initials:

☐ I authorize the release of any clinical information to my insurance company that will assist in the payment of insurance claims.

Your initials:

☐ I agree to promptly notify Stoner Counseling Services, LLC if there is any change regarding my insurance coverage or my personal identifying information.

Your initials:

☐ I understand that Stoner Counseling Services, LLC does not bill auto insurance companies for treatment related to motor vehicle accidents, or similar.

Your initials:

PRINTED CLIENT NAME	
CLIENT SIGNATURE (Must be original signature)	**DATE** (mm/dd/yyyy)