

**Client Billing Information Required for Insurance Coverage  
Stoner Counseling Services, LLC  
@ Phoenix Offices, LLC**

2101 4<sup>th</sup> AVE. E STE 200, Olympia, WA 98506-4729  
Office: 360.786.9499 Fax: 360.786.0758

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**

Legal name (first, MI, last):	
Birthdate (mm/dd/yyyy):	
Social Security Number:	
Mailing address line 1:	
Mailing address line 2:	
Home or cell phone:	

**Insurance Policy Holder Information**

If the policy holder and client are the same person check this box. => =>	
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Name (first, MI, last):	
Social Security Number:	
Birthdate (mm/dd/yyyy):	
Mailing address line 1:	
Mailing address line 2:	
Home or cell phone:	
Employer (that sponsors the coverage):	

**Insurance Information**

Insurance Name:	
Plan #:	
Group number:	
Phone number::	
Mailing address line 2:	
Home or cell phone:	
Copay amount:	
If TriCare, TriWest or Veterans Administration we must have your <b>Department of Defense (DoD) Benefits Number (DBN):</b>	

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

Insurance Name:	
Plan #:	
Group number:	
Phone number:	

**Client Attestation**

<b>Initial each statement on the right (if electronic signature add initials)</b>	<b>Initials</b>
I authorize my insurance company to send payments directly to Stoner Counseling Services, LLC, and or William (Bill) Stoner, MA, LMHC for services rendered.	
I accept full responsibility independent of my insurance and agree to pay all co-payments, deductibles, and balances due.	
I authorize the release of any diagnostic information to my insurance company that will assist in the payment of insurance claims.	
I agree to promptly notify Stoner Counseling Services, LLC if there is any change regarding my insurance coverage or my personal identifying information.	
I understand that Stoner Counseling Services, LLC does not bill: <ul style="list-style-type: none"> <li>• Auto insurance companies related to motor vehicle accidents.</li> <li>• Workers compensation claims.</li> <li>• Medicaid programs (e.g., Apple Health)</li> </ul>	

Printed client name:	
Client signature: (if electronic signature add initials.	
Date Signed:	