(717) 560-9969
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SAMARITAN COUNSELING CENTER
Healthy Minds. Strong Communities.

1803 Oregon Pike
Lancaster, PA 17601
www.scclanc.org

Client Insurance Form

Client Name:_____ Date of Birth:_____ Today's Date:_____

☐ I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered.

Insurance Company:_____

Member ID:_____ Group Number:_____

Policy Holder Name:_____ Date of Birth:_____

Your relationship to the Policy Holder: _____

If you have a secondary insurance policy, please complete the following:

Insurance Company:_____

Member ID:_____ Group Number:_____

Policy Holder Name:_____ Date of Birth:_____

Your relationship to the Policy Holder: _____

Acknowledgement

I authorize Samaritan Counseling Center to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Samaritan Counseling Center if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Samaritan Counseling Center and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

Signature:_____

Printed Name:_____