PREAUTHORIZATION FOR HEALTH CARE

- I authorize **Employee & Family Assistance Consultants, LLC** to keep my signature on file for billing purposes.
- I authorize **Employee & Family Assistance Consultants, LLC** to release to insurance/EAP company all information necessary for claims payment purposes.
- I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's Name: ____

Client's D.O.B. ______/_______/________

Client's Home Address: ____

City: ______________________________ State:___________ Zip: ______________

Tel #1: ________________________ **Check: cell home work** ***Check: OK to leave message***

Tel # 2:________________________ **Check cell home work** ***Check: OK to leave message***

Name of parties with whom we may leave messages: (1) ____________________**/Relationship:**________________

(2) _______________**/Relationship:**________________**(3)**___________________**/Relationship:**_______________

EMERGENCY CONTACT: Name ____________________________ **Telephone #** ________________________

Patient Status: **Single** _____ **Married** _____ **Other**_____

Employed _____ **Full-time Student**_____ **Other**_____

Relationship to Insured: Self ___________ Spouse ___________ Child ___________ Other _____________

Insured's Name: ____ D.O.B. ______/_______/________

Insured's Home Address: ____

City: __________________ State:______Zip: __________ Insured's SS# ______________________________

Insured's Policy #: ____ Group #: ______________________________

Insured's Employer's Name: ____ Date Hired: ______________

Patient or Insured's Signature: ____

Date: ______/_______/________ REFERRED BY: ____