PREAUTHORIZATION FOR HEALTH CARE

- I authorize **Kelly H. Freund, LMHC, CEAP** to keep my signature on file for billing purposes.
- I authorize **Kelly H. Freund, LMHC, CEAP** 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: ______________________ **Circle: cell home work** **Circle:** ***OK to leave message***

Tel # 2:______________________ **Circle: cell home work** **Circle:** ***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: ______________________________________

Patient or Insured's Signature: ____

Date: ______/_______/________ REFERRED BY: ____

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