CLAIMS REGISTRATION & INSURANCE BENEFIT AUTHORIZATION FORM

KoKoRo Counseling & Integrated Health Services P: 832.632.8118 / eF: 713.422.2428

Patient's Last Name	Fi	rst	MI			
Mailing Address			Apt or Unit #			
City	Sta	State		Zip		
_() Home Telephone	Ce	Cell Number		e-mail		
Date of Birth	Α	ge	Soc	ial Security #		
Marital Status: Single	Married Divorced	Co-habitating	Other	Sex: Male	Female	
Employer Name, Address, Ph & Position: GUARANTOR NAME-(Person to Bill if Other Than Patient):						
Guarantor's Date of Bir	th:	Guarantoi	's (Subscriber's) Ben	efit I D ·		
			o (oubcombor o) born	one non		
	Apt/Unit #			ZI		
Mailing Address authorize the release of any media mefits, if applicable, to be paid dia mancially responsible for all non-cat t reimbursed by my benefit carrie file. I understand & give my auth tice (business days) will be charg d SNOTS are not reimbursable be t a guarantee they will pay for se yment. I've been given the oppor	Apt/Unit # cal or personal health information rectly to KoKoRo Counseling & In overed services provided by any er will be charged first to my credi norization for Non- emergency "Nonged to my credit card on file or my by my insurance carrier. My signa rvices. I understand I am financia rtunity to verify my own benefits.	City n necessary for proceeding the provider (s) affiliate-provider (s) affiliate-provider (s) of Shows" or short-ny deposit applied with ture below also indially responsible and	State essing and payment of service of KoKoRo Counseling & into then deducted from my depotice cancellations (SNOTS) the deposit replenished to concates my understanding that agree I'll pay for billed service.	ces due and direct e(s) it uses. I unde egrated Health Ser soit of one full sess not voice confirme tinue services. I ur a verbal approval es in full if my insu	my insurance restand I will be he rvices. Open bala sion fee for 90834 d with at least 4t inderstand "No-Sh by my insurance irance carrier der	
Mailing Address authorize the release of any media benefits, if applicable, to be paid dia benefits, if applicable for all non-count reimbursed by my benefit carrie benefits if ile. I understand & give my authorize (business days) will be charged SNOTS are not reimbursable but a guarantee they will pay for selegement. I've been given the opport	Apt/Unit # cal or personal health information rectly to KoKoRo Counseling & Ir overed services provided by any er will be charged first to my credinorization for Non- emergency "Noged to my credit card on file or my my insurance carrier. My signal rivices. I understand I am financial tunity to verify my own benefits. TE THE SECTION BEL	City n necessary for produce of the provider (s) affiliate-provider (s) it card on file and/or o Shows" or short-ny deposit applied with the production of	State essing and payment of service or any 3rd-party service of KoKoRo Counseling & into then deducted from my depotice cancellations (SNOTS) the deposit replenished to concates my understanding that agree I'll pay for billed service Date: WITH YOUR INSUE	ces due and direct e(s) it uses. I unde egrated Health Ser soit of one full sess not voice confirme tinue services. I ur a verbal approval es in full if my insu	my insurance restand I will be he rvices. Open bala sion fee for 90834 d with at least 4t inderstand "No-Sh by my insurance irance carrier der	
Mailing Address authorize the release of any media benefits, if applicable, to be paid dia benefits, if applicable for all non-count reimbursed by my benefit carrie benefits if ile. I understand & give my authorize (business days) will be charged SNOTS are not reimbursable but a guarantee they will pay for selegement. I've been given the opport	Apt/Unit # cal or personal health information rectly to KoKoRo Counseling & Ir overed services provided by any er will be charged first to my credinorization for Non- emergency "Noged to my credit card on file or my my insurance carrier. My signal rivices. I understand I am financial tunity to verify my own benefits. TE THE SECTION BEL	City n necessary for produce of the provider (s) affiliate-provider (s) it card on file and/or o Shows" or short-ny deposit applied with the production of	State essing and payment of service or any 3rd-party service of KoKoRo Counseling & into then deducted from my depotice cancellations (SNOTS) the deposit replenished to concates my understanding that agree I'll pay for billed service Date: WITH YOUR INSUE	zes due and direct e(s) it uses. I unde egrated Health Se sit of one full sess not voice confirme tinue services. I ur a verbal approval es in full if my insu	my insurance restand I will be he rices. Open bala ion fee for 9083a d with at least 40 derstand "No-Sh by my insurance irance carrier der	
Mailing Address authorize the release of any media enefits, if applicable, to be paid dia nancially responsible for all non-count reimbursed by my benefit carrie in file. I understand & give my authorice (business days) will be charged SNOTS are not reimbursable by it a guarantee they will pay for seatyment. I've been given the opport Signature: PLEASE COMPLE ISSURANCE Company:	Apt/Unit # cal or personal health information rectly to KoKoRo Counseling & Ir overed services provided by any ser will be charged first to my credit norization for Non- emergency "Noged to my credit card on file or my my insurance carrier. My signarvices. I understand I am financia tunity to verify my own benefits. TE THE SECTION BEL	City In necessary for proceeding the provider (s) affiliate-provider (s) it card on file and/or o Shows" or short-ny deposit applied with ture below also indically responsible and OW, IN FULL,	State essing and payment of service of KoKoRo Counseling & into then deducted from my depotice cancellations (SNOTS) the deposit replenished to concates my understanding that agree I'll pay for billed service	ces due and direct e(s) it uses. I unde egrated Health Ser soit of one full sess not voice confirme tinue services. I un a verbal approval es in full if my insu	my insurance restand I will be hervices. Open bala- ision fee for 9083- isid with at least 4th derstand "No-Sh by my insurance irance carrier der	
Mailing Address authorize the release of any media penefits, if applicable, to be paid dis pancially responsible for all non-counts reimbursed by my benefit carries in file. I understand & give my authorice (business days) will be charged SNOTS are not reimbursable but a guarantee they will pay for seasyment. I've been given the opport Signature: PLEASE COMPLE asurance Company: ubscriber's Name:	Apt/Unit # cal or personal health information rectly to KoKoRo Counseling & Ir overed services provided by any er will be charged first to my credinorization for Non- emergency "Noged to my credit card on file or my my insurance carrier. My signarvices. I understand I am financiartunity to verify my own benefits. TE THE SECTION BEL	City n necessary for produce of the provider (s) affiliate-provider (s) it card on file and/or o Shows" or short-ny deposit applied with the three below also indially responsible and OW, IN FULL,	State essing and payment of service vices or any 3rd-party service of KoKoRo Counseling & interest in then deducted from my depotice cancellations (SNOTS) the deposit replenished to concates my understanding that agree I'll pay for billed service Date: WITH YOUR INSUE Group #:	zes due and direct e(s) it uses. I unde egrated Health Se, sit of one full sess not voice confirme tinue services. I ur a verbal approval es in full if my insu	my insurance rstand I will be he rvices. Open bala ion fee for 9083e d with at least 46 derstand "No-Sh by my insurance irance carrier der	
Mailing Address authorize the release of any media enefits, if applicable, to be paid dia nancially responsible for all non-co- to reimbursed by my benefit carrie in file. I understand & give my authorice (business days) will be charged and SNOTS are not reimbursable be to a guarantee they will pay for se ayment. I've been given the opport	Apt/Unit # cal or personal health information rectly to KoKoRo Counseling & Ir overed services provided by any er will be charged first to my creditorization for Non- emergency "Noged to my credit card on file or my by my insurance carrier. My signaryices. I understand I am financia tunity to verify my own benefits. TE THE SECTION BEL	City In necessary for proceeding the provider (s) affiliate-provider (s) it card on file and/or o Shows" or short-ny deposit applied witture below also indially responsible and	State essing and payment of service vices or any 3rd-party service of KoKoRo Counseling & interpretation (SNOTS) then deducted from my depositice cancellations (SNOTS) the deposit replenished to concates my understanding that agree I'll pay for billed service Date: WITH YOUR INSUE Subscriber's I Group #: Is Authorizati	zes due and directes(s) it uses. I unde egrated Health Sesonot voice confirme tinue services. I ura a verbal approval es in full if my insusant hance in full in fu	my insurance rstand I will be he rvices. Open bala sion fee for 9083 ded with at least 48 nderstand "No-Sh by my insurance irrance carrier der	