CLAIMS REGISTRATION & INSURANCE BENEFIT AUTHORIZATION FORM

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

Please print clearly to help avoid billing errors. This form is kept on file/sent to 3rd party billers for claims processing ONLY

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD & DRIVER'S LICENSE (F&B) WITH THIS REGISTRATION

_____

Patient's Last Name **First** **MI**

_____

Mailing Address **Apt or Unit #**

_____

City **State** **Zip**

_(_____)_____

Home Telephone **Cell Number** **e-mail**

_____

Date of Birth **Age** **Social Security #**

Marital Status: Single Married Divorced Co-habitating Other **Sex: Male Female**

Employment Status: Full Time Part Time Self-employed F.T. Student Unemployed Retired On-Disability

Employer Name, Address, Ph & Position: _____

_____

GUARANTOR NAME-(*Person to Bill if Other Than Patient*): _____SS#: _____-___-_____

Guarantor's Date of Birth: _____Guarantor's (Subscriber's) Benefit I.D.: _____

_____

Mailing Address **Apt/Unit #** **City** **State** **ZIP**

*I authorize the release of any medical or personal health information necessary for processing and payment of services due and direct my insurance benefits, if applicable, to be paid directly to KoKoRo Counseling & Integrated Health Services or any 3rd-party service(s) it uses. I understand I will be held financially responsible for all non-covered services provided by any affiliate-provider (s) of KoKoRo Counseling & integrated Health Services. O*pen balances not reimbursed by my benefit carrier will be charged first to my credit card on file and/or then deducted from my deposit of one full session fee for 90834 held on file. I understand & give my authorization for Non- emergency "No Shows" or short-notice cancellations (SNOTS) not voice confirmed with at least 48hr notice (business days) will be charged to my credit card on file or my deposit applied with deposit replenished to continue services. I understand "No-Shows" and SNOTS are not reimbursable by my insurance carrier. My signature below also indicates my understanding that a verbal approval by my insurance is not a guarantee they will pay for services. I understand I am financially responsible and agree I'll pay for billed services in full if my insurance carrier denies payment. I've been given the opportunity to verify my own benefits.

Signature: _____ Date: _____

PLEASE COMPLETE THE SECTION BELOW, IN FULL, WITH YOUR INSURANCE INFORMATION

Insurance Company: _____ Subscriber's Birthdate: _____

Subscriber's Name: _____ Group #: _____

Subscriber's ID#: _____ Is Authorization Needed: YES NO

Authorization# (If Pre-cert Required): _____ & # of Visits Allowed/Approved: _____

Start of Plan Calendar Year: _____/_____/_____ Other Info: _____

Fax / Upload completed form to 713.422.2428. Form required 48 hrs before 1st desired appointment is confirmed