# MIDWEST CENTER FOR PSYCHOTHERAPY AND SEX THERAPY
## Insurance Update Information Form

***Chart #*** _____

**Client Information:**

Last Name _____ First _____ MI_____ Date of Birth ____ ____ ____

Legal Sex: M / F Address_____City_____ State _____ Zip _____

**Primary Insurance Company**_____ **Name of Policyholder**_____

Group#_____ **and/or** Subscriber#_____ Policyholders SS#_____

Policyholder Address (if different from client) _____

Relationship to client _____ Effective Date of Coverage _____ DOB of Policyholder _____ _____ _____

**Secondary Insurance Company**_____ **Name of Policyholder**_____

Group#_____ **and/or** Subscriber#_____ Policyholders SS#_____

Policyholder Address (if different from client) _____

Relationship to client _____ Effective Date of Coverage _____ DOB of Policyholder _____ _____ _____

## AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE PROVIDERS

- I authorize and understand the release of claim form information to all my insurance companies or managed care organization.
- I authorize and understand the release of treatment reports (written and/or verbal) that may be requested by my insurance company or managed care organization.
- I authorize and understand the use of this form as authorization for all my insurance submissions.
- I permit this signed authorization to be used in place of the original.

I understand I have the right to revoke this authorization at any time. I also understand my revocation of this authorization must be in writing. To obtain a copy of the authorization revocation form I may contact my treating therapist or any Midwest Center for Psychotherapy and Sex Therapy staff person. I am aware my revocation will not be effective if: (1) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself; or, (2) to the extent the treating therapist and/or Midwest Center for Psychotherapy and Sex Therapy has already acted in reliance upon this authorization.

I understand I am under no obligation to sign below and authorize Midwest Center for Psychotherapy and Sex Therapy to use and/or disclose my health information and by not signing take responsibility for payment of treatment.

_____ _____

Name of policyholder *(please print)* Subscriber number

→ **Signature of client** **Date**

* Signing or typing your name here constitutes a signature.

→ **Signature of Parent or Guardian** **Date**

* Signing or typing your name here constitutes a signature.

To simplify our accounting, we prefer insurance benefits to be paid by the insurance company directly to us. We would appreciate; therefore, you are signing the Assignment of Benefits directive below.

## ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make payments directly to Midwest Center for Psychotherapy and Sex Therapy for psychotherapy services. I accept personal responsibility for the deductible amount and for any balance outstanding after payment of such benefits. I further understand that copies of this authorization will be used in subsequent billings and will be accepted as valid as the original. *(please sign below)*

→ **Client (or parent/guardian)** _____ **Date** _____

* Signing or typing your name here constitutes a signature.