LAKESIDE
COUNSELING ASSOCIATES, LLC

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2021 UPDATED FORM

Patient Information:

Last Name: ___________________________________ First Name: _____________________Middle Initial:________

Address: ____City:____________________State: _____Zip:_________

Home Phone: __________________________Work:___________________________Cell:______________________

SSN: ____________________________Sex:________Birthdate:____________________Marital Status:____________

EMAIL: ____

Responsible Party Information: (If different from above)

Last Name:__________________________________First Name:_______________________Middle Initial:________

Address: _______________________________________City:_______________________State:_____Zip:_________|

Home Phone:____________________________Work:_________________________Cell:______________________

Insurance Information: Birthdate and SSN# are required for Insurance Purposes

Primary Insurance Company:____

Subscriber Name: _________________________________Birthdate:______________SSN#:____________________

Relationship to patient: _________________ID#:________________________Group Number#: _________________

Secondary Insurance Company:____

Subscriber Name:_________________________________Birthdate:_______________SSN#:____________________

Relationship to patient: __________________ID#:______________________GroupNumber#:___________________

******You are responsible for providing correct and complete INSURANCE Information******

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Lakeside Counseling Associates, LLC to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim:

I _________________________________hereby authorize ________________________to pay and hereby assign directly to
(Name of Insured) (Name of Insurance Company)

Lakeside Counseling Associates, LLC all benefits, if any otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Lakeside Counseling Associates, LLC will be credited to my account, in accordance with the above said assignment.

____ ____
(Authorized Signature of Subscriber) (Date)