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# LAKE SIDE

## COUNSELING ASSOCIATES, LLC

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### 2025 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\*\*\***

#### **PLEASE COMPLETE THE SECTION BELOW**

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)