DBT of Southern Oregon
Integrated Health Services, INC
Ph: (541)621-0303 Fax: (458) 226-2072

INSURANCE RELEASE FORM

Client Name:	**Date:**

Insurance Information		For Secondary Insurance	
Insurance ID #	______________________	Insurance ID #	______________________
Ins Co. Name	______________________	Ins. Co. Name	______________________
Policy Holder's Name	______________________	Policy Holder's Name	______________________
Relationship to client	______________________	Relationship to client	______________________
Policy Holder's Address	______________________	Policy Holder's Address	______________________
	______________________		______________________
Group #	______________________	Group #	______________________
Policy Holder's DOB	______________________	Policy Holder's DOB	______________________
Male _____ Female _____		Male _____Female _____	
Employer	______________________	Employer	______________________

Deductible $_________ Has it been met? Yes ☐ No ☐ Co-payment $_______
Person responsible for deductible and co-payments: ______________________________
Address of responsible party:

____
Street City State Zip

Does your insurance company authorize these visits? Yes ☐ No ☐
Authorization number ________________________________ Number of visits ____
Referred by:______________________________________
Nearest relative or friend I can contact in case of emergency:

____
Name Relationship Phone

IF YOU WOULD LIKE ME TO BILL YOUR INSURANCE COMPANY FOR YOU, PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW:

I understand that I am ultimately responsible for fees based on the amounts determined by my health insurance, and I agree to pay any balance indicated by my insurance as my responsibility. I further understand and agree that I will be charged $40.00 for a missed Individual session that I do not cancel within 24 hours and $80.00 for any individual session I do not call to cancel and do not attend. Group sessions where I do not attend for any reason will result in a $25.00 charge. I hereby authorize the release of any personal information necessary to process my insurance claim, including my diagnosis. I understand the diagnosis may become a permanent part of my insurance records. I authorize payments directly to Integrated Health Services, INC.

RESPONSIBLE PARTY SIGNATURE____
Date

DBT of SOUTHERN OREGON THERAPIST SIGNATURE ________________________________
Date