JORDAN WEST FAMILY COUNSELING CHANGE REQUEST

PATIENT INFORMATION

Client Name		DOB	
Insured Address: City, State, Zip			
Phone			

PRIMARY PAYMENT

Payment Source		Phone #	
Payment Source Address City, State, Zip			
*Authorization Number Not Optional for EAP			EAP? Yes ☐ No ☐
Insured Name		Insured DOB	
Insured Address: City, State, Zip			

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Payment Source

and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize Jordan West Family Counseling to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____
Patient Name Authorized Person

_____ _____ _____
Signature Relationship to Patient Date

Include a copy of the FRONT and BACK sides of the Insurance Card.

For Internal Use Only							
Form Accepted By				Date Accepted			
MS		TN		Updated by		Date Completed	