Airmid Intake Form and Insurance Information

Patient Name: ____

Relationship to Primary Cardholder: _____________________________

Street Address: ____

City, State, Zip: ____

Patient date of birth: _______________ Marital Status: _______________

Patient Insurance ID# (with letters): _______________________________

Phone # of Provider Services & Mental Health (back of card):

____

Name of Insured (Primary Card Holder): ___________________________
(If other than patient)

Insured's Street Address: ______________________________________

Insured's City, State, Zip: ______________________________________

Patient's relationship to insured: ________________________________

Insured's date of birth: ____

Insured's Social Security#: ______________________________________

I authorize the release of any information necessary to verify and process insurance claims. I fully understand that I am responsible for all charges not covered by my insurance carrier. I am aware that an agent of my insurance company, third-party payer and insurance administrator may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I authorize payment directly to Airmid Wellness and Counseling Center, LLC.

I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: ____________________________________

Date: ________________________