10 McKown Road, Suite 202
Albany, NY 12203
518-466-3100
synergycounselingassociates@gmail.com
www.synergycounselingassociates.org

Client Insurance and Billing Form

Name:

I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered. ☐

Billing Information

Name on Credit/ Debit Card: _____

Credit Card Number:_____

Exp. Date:_____ Security Code:_____

Insurance Information

Insurance Company				
Member ID				
Priority	Primary☐		Secondary☐	Tertiary☐
Policy Group	(leave blank if unsure)			
Plan Name	(leave blank if unsure)			
Policy Holder	Self☐			Other☐
Client Relationship	Spouse☐	Child☐	Life Partner☐	Other☐
Name (if not self)			DOB:	Administrative Sex:
Address				
	City/State:		Zip:	Country:
Phone	Mobile:		Home:	Work:

Acknowledgement

I authorize Synergy Counseling Associates to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Synergy Counseling Associates if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Synergy Counseling Associates and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

Signature:_____ Date:_____

Diane Lykes
Clinical Director