PATHWAYS
Mental Health Services

4804 – A & B, Lacey Blvd. SE Lacey, WA 98503
Phone: 360-799-5782 ~ Fax 360-539-1715

831 12th Avenue Longview, WA 98632
Phone: 360-7994556 ~ Fax : 360-846-1722

Insurance and Billing Information

Patient Name: _____
First MI Last

Birthdate: _____

INSURANCE INFORMATION

ALL APPLICABLE INFORMATION (FOUND ON YOUR CARD) MUST BE COMPLETED

Person financially responsible for account: _____
Relationship to patient:_____Birthdate:_____SSN: _____

PRIMARY INSURANCE:

Patient's Primary Insurance: _____
Subscriber/Member ID #: _____
Group: _____
Primary Insured Name: _____ and DOB: _____
Required for TRICARE clients ONLY: Sponsor's SSN: _____

SECONDARY INSURANCE (if applicable)

Insurance Name: _____
Subscriber/Member ID# _____ Group # : _____
Primary Insured Name and DOB: _____ DOB: _____

HAVE YOU CONTACTED YOUR INSURANCE COMPANY TO VERIFY YOUR ELIGIBILTY FOR MENTAL HEALTH SERVICES?

Yes: ___ No: ___ *If not, please do so prior to your first appointment.*

TREATMENT CONSENT, FINANCIAL RESPONSIBILITY, AND RELEASE OF INFORMATION

I agree to be financially responsible for cancelled appointments in accordance with the Pathways MHS cancellation policy as documented by my signature on the Informed Consent. I authorize insurance benefits to be paid directly to Pathways Mental Health Services and that Pathways may release any information to my insurance provider required for processing my claims.

Signature of Patient or Guardian:_____ Date: _____

Printed Name: _____

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