LEGACY
MENTAL HEALTH CENTER

Permission for ACE to Bill Ins

Patient Information:

Therapist: _____

_____ Date: _____

Patient Name (Print)

Date of Birth: _____ Age: _____ Gender (M, F): _____

Address: _____
(Street, Unit (if applicable), City, Zip Code)

_____ _____ _____

Home Phone | Cell Phone | Work Phone

May We Leave Messages: _____ _____ _____

Home (Y/N) | Cell (Y/N) | Work (Y/N)

Soc Sec #: _____ Emergency Contact: _____

Emergency Phone: _____

Marital Status: ____ Single ____ Married ____ Widowed

____ Divorced ____ Partnered

Employer: _____ Occupation: _____

Email: _____

Primary Insurance Company: _____ Phone: _____

Ins Claims Address: _____
(Street, City, Zip Code)

Policy ID: _____ Group Plan ID: _____

Name of Policyholder: _____ Relationship: _____

Address: _____
(Street, Unit (if applicable), City, Zip Code)

Social Security Number: _____ Employer: _____

Policyholder's Date of Birth: _____

Secondary Insurance Company: _____ Phone: _____

Ins Claims Address: _____
(Street, City, Zip Code)

Policy ID: _____ Group Plan ID: _____

Name of Policyholder: _____ Relationship: _____

Address: _____
(Street, Unit (if applicable), City, Zip Code)

Social Security Number: _____ Employer: _____

Policy Holder's Date of Birth: _____

Responsible Party:

Name	Relationship	Phone Number

Address: _____
(Street, Unit (if applicable), City, Zip Code)

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date