Serenity Mental Health Services
Insurance Information

Primary Coverage: _____
Insurance Co. Name: _____
Policy Holder's Name: _____
Insurance Telephone #: _____
Address: _____
ID #: _____Policy #: _____Group #: _____

Insurance Signature Authorization
To Permit Payment of Insurance Benefits to Provider

I, _____ authorize the release to my insurance company of medical information or other information necessary to process claims or determine benefits. I also request that payment of authorized insurance benefits be paid on my behalf to Diana Smith for any services furnished me by her. In the event that my insurance company directly sends myself the payment I agree to turn the payment, in full, over to Diana Smith.

If I am a Medicaid recipient, I understand that it is my responsibility to provide a referral card according to Managed Care instructions. If I am a Medicaid recipient, I will allow the South Dakota Medicaid Program, Medical Services, to access any and all material which may be deemed confidential by any regulatory or licensing agency, board or commission as required by Title XIX.

_____ _____
Client Signature/guardian signature Date

_____ _____
Witness signature Date

For you information: In certain cases, some therapy services are not covered by insurance, i.e., marital therapy, and collateral therapy.