Serene Minds, LLC

410 Foulk Road, Suite 102
Wilmington, DE 19803

80 Omega Dr, Bldg C
Newark, DE 19713

CLIENT AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF BENEFITS

NAME OF CLIENT ____Male______Female ________

CLIENT'S SOCIAL SECURITY #__________________________ CLIENT'S DATE OF BIRTH ____________________

PARENT / GUARDIAN (if applicable) _________________________ RELATIONSHIP TO CLIENT _________________

ADDRESS ____

CITY ____STATE ___________________ ZIP CODE ________________

HOME PHONE #____________________ WORK PHONE #_____________________CELL#______________________

EMAIL ADDRESS: ____

EMPLOYER ____

ADDRESS ____

PRIMARY INSURANCE ____

ADDRESS ____ PHONE #____________________________________

NAME OF INSURED ____

ADDRESS OF INSURED ____

INSURED'S DATE OF BIRTH ______________________ INSURED'S SSN ___________________________________

INSURED'S EMPLOYER____

PLAN NAME ______________________POLICY #_______________________GROUP # _______________________

SECONDARY INSURANCE (if applicable) ____

ADDRESS ____PHONE #______________________________

POLICY #____________________________________GROUP #______________________________________

NAME OF POLICY HOLDER____

ADDRESS OF POLICY HOLDER (if different than client) ____

POLICY HOLDER'S DATE OF BIRTH ______________________POLICY HOLDER'S SSN________________________

POLICY HOLDER'S EMPLOYER____

EMERGENCY CONTACT____

RELATIONSHIP____ PHONE NUMBER _____________________________

PRIMARY PHYSICIAN & PHONE #____

REFERRED BY ____

PLEASE READ & INITIAL EACH OF THE BOXES BELOW:

___ I authorize Serene Minds, LLC to submit visits to my insurance provider, when applicable.

___ I authorize Serene Minds, LLC to release any medical or other necessary information to process claims to my insurance provider.

___ I acknowledge payments of any insurance benefits due on my behalf are made to Serene Minds, LLC, and accept responsibility for all co-pays, co-insurance, and deductibles.

___ I acknowledge that I am signing this consent in the absence of coercion, duress, or deceit.

____ _____________________

Client Signature or Parent / Guardian Signature Date (mm/dd/yyyy)