Lacamas Counseling & Psychiatry
3400 SE 196th Ave, Ste. 102
Camas, WA 98607
(360) 975-0512 - Fax: (360) 693-2045
info@lacamascounseling.com

LACAMAS COUNSELING

Insurance Authorization

If you would like to use your in-network or out-of-network insurance benefits for counseling, please complete the following information.

CLIENT NAME: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY PHONE: _____

INSURANCE ID: _____ GROUP ID: _____

PRIMARY INSURED INFORMATION (if different than you)

NAME: _____

DATE OF BIRTH: _____

GENDER: _____

PHONE NUMBER: _____

ADDRESS: _____

RELATIONSHIP TO YOU: ☐ Spouse/Partner, ☐ Parent, ☐ Other _____

By signing below:

- I am requesting Lacamas Counseling & Psychiatry to provide superbills for services rendered which will include my personal information, diagnosis, dates of service, payments, and treatment details.
- I am aware that further information may be required by my insurance company to justify medical necessity, such as intake assessment, treatment plans, treatment reviews, clinical assessments, and clinical consultations.
- I agree to pay the hourly rate of for any services provided including additional paperwork from insurance company, clinical reviews and consultations, file audits, and other record requests.
- I am aware that my insurance company may not cover the services provided based on their own criteria of medical necessity, authorization, or other reasons deemed by the insurance company.
- I agree to pay in full for all services provided at the time of service.

Client /Guardian Signature Date

Provider Date