

Bowden & Associates  
Psychological and Counseling Services LLC  
365 Riffel Road, Suite B, Wooster Ohio  
330-345-3461

**Insurance Information/Authorization to Bill Third Party**

*(Please allow us to copy your insurance card.)*

Did you obtain prior authorization/pre-certification?

\_\_\_\_\_ Yes      \_\_\_\_\_ No      \_\_\_\_\_ Not Required

**Primary Insurance:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group# \_\_\_\_\_

SSN of Subscriber: \_\_\_\_\_

Subscriber's Address if different from patient:

\_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group# \_\_\_\_\_

SSN of Subscriber: \_\_\_\_\_

Subscriber's Address if different from patient:

\_\_\_\_\_

**Authorization to Bill Third Party**

I hereby request that Bowden & Associates bill the charges for any eligible services for the above-named client to my insurance company. I also authorize the release of any medical/psychological information necessary to process claims to the plan administrator or authorized agent if applicable for the purpose of determining benefits payable in connection with my claims.

I further authorize my insurance company to reimburse Bowden & Associates directly. I understand that if my insurance does not cover the billed services within 60 days, I am responsible for payment of such services. Any insurance payment received by me will be forwarded to Bowden & Associates.

\_\_\_\_\_  
Signature of Subscriber

\_\_\_\_\_  
Date