

Health Insurance Name	
Enrollee Name	
Enrollee ID	
Date Of Birth	
Initial diagnosis:	
Group #	
Provider specialty, procedure code, DSM code	
Benefits	
Co-pays	
Deductible	

I \_\_\_\_\_ agree to allow Namaste Family Services, LLC to contact my health Insurance to obtain benefits information or other relevant information to ensure continuation of my benefits, This may include but not limited to:

1. Diagnosis
2. Psychosocial History
3. Goals for treatment
4. Referrals to outside community resources

I also understand that this release allows Namaste Family Services to bill my insurance company; however, it is my responsibility to ensure that billable services are covered. If you insurance company denies coverage for any service provided, I understand that I am responsible for any charges incurred.

I understand that all information released will follow the guidelines under the Health Insurance Portability and Accountability Act of 1996 commonly known as HIPAA.

\_\_\_\_\_  
 Client name/ date

\_\_\_\_\_  
 Witness/date