OLYMPIC PSYCHIATRIC CARE

Health Insurance Authorization Form

Olympic Psychiatric Care participates in most insurance plans, including Medicare. If you are insured with a plan that we do business with, please complete the form below and we will submit your claims and assist you in any way we reasonably can to help get your claims paid.

Please note that we are not in-network with all insurance companies, and that out-of-network coverage may result in higher costs to the patient. For a complete list of insurance companies we are in-network with, please ask a member of our staff.

Please list all health insurance carriers that you would like us to bill, and provide your state issued photo identification card, as well as your insurance card for our staff to make a copy.

Note: If you are not the subscriber, you will need to include the subscriber name, date of birth, and address in order for us to bill your insurance.

Primary Insurance

Insurance Name:_____ ID#:_____ Group#:_____

Subscriber Name:_____ Date of Birth:_____

Subscriber Address:_____ City/State/Zip:_____

Secondary Insurance

Insurance Name:_____ ID#:_____ Group#:_____

Subscriber Name:_____ Date of Birth:_____

Subscriber Address:_____ City/State/Zip:_____

I hereby authorize payment of medical benefits to be billed to my insurance by Olympic Psychiatric Care (OPC). I certify that I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me not covered by my insurance. I agree to pay all co-payments and deductibles at the time of service, and all co-insurance upon receipt of an invoice.

I hereby authorize OPC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, OPC can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that OPC took before receiving my revocation.

Signature:_____ Date:__/__/____

Print Name:_____