Client #_____

Name_____ Birthdate_____/_____/_____

Pathway Health Clinic Private Insurance Authorization

We are now billing Private Insurance. However, we are not in network with all carriers at this time.

(We are continuing to expand our billing to other Insurance companies.)

Do you have private health insurance? ____Yes Company:_____.

(If you are covered, please make your card available for verification.)

_____No (if no STOP, sign and date at bottom)

Insured through (mark only one): _____ parent _____spouse _____ self ___ other (explain)

Explanation _____

If you mark self, who is your employer? _____

(AGE 26 AND UNDER ONLY!) If your insurance **is** through your parents' policy, **considering privacy issues**, do you want Pathway Health Clinic to bill your health insurance?

_____Yes (Please fill out parent info) _____No

If your insurance **is** through your parent, please complete **all** of the following information:

Insured Parent Name_____D.O.B. _____/_____/_____

Address_____

Telephone #_____Employer_____

If your insurance **is** through your spouse or other, please complete the following information:

Spouse Name_____ D.O.B._____/_____/_____

Address_____

Telephone #_____ Employer_____

_____ _____/_____/_____

Client's signature Date