New Dawn Counseling Center
3312 Northside Dr., Suite D202
Macon, Ga. 31210
PH: (478) 254-3751 Fax: (478) 254-3752

Consent for Treatment and Billing

Client(s)

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Address: _____
_____
PH: Home: _____ Cell: _____ Work: _____

Parent/Guardian (if applicable)

Name of Parent/Guardian: _____
Address: _____
_____
PH: Home _____ Cell: _____ Work: _____

Person Responsible for Payment

Name of Parent/Guardian: _____
Address: _____
_____
PH: Home _____ Cell: _____ Work: _____

Primary Insurance

Name of Insurance Company: _____
Insurance ID: _____ Insurance Group: _____
Name of Policy Holder _____
Relationship to Policy Holder: _____
If Policy Holder is other than client, provide the following information about policy holder:
Date of birth: _____
Address: _____
Place of Occupation: _____ Phone Nr: _____

Do you have any additional insurance: Yes ___ No __ If yes, complete the next section:

Secondary Insurance

Name of Insurance Company: _____
Insurance ID _____ Insurance Group: _____
Name of Policy Holder: _____
Client's Relationship to Policy Holder: _____
If Policy Holder is other than client provide the following information *about policy holder*:
Place of Occupation: _____ Date of birth: _____
Address: _____

Authorization for Payment to be made directly to New Dawn Counseling Center and for New Dawn to release information to Insurance Company

I hereby request that the insurance company listed above reimburse New Dawn Counseling Center directly for services covered. I hereby authorize **New Dawn Counseling Center personnel** to release information about diagnosis, dates of treatment, and services provided in the course of my evaluation and/or treatment as may be necessary to process claims for insurance reimbursement. I understand that my therapist will have discussed my diagnosis and treatment plan with me prior to releasing this information to the insurance company. Occasionally, an insurance company may require more detailed information. I hereby authorize release of such information as requested by the insurance company. I agree to promptly pay for charges incurred if for any reason my insurance carrier does not pay any portion of it.

*Client Signature _____ Date _____

*Signature of the custodial parent or guardian is required for clients under 18 years of age.