David Goldstrom, DMin.
Licensed Marriage and Family Therapist

To: New patients of David Goldstrom, DMin, LMFT

Please read and complete the following insurance forms:

The two-page Insurance Information and Assignment Form

Counseling may be all or in part reimbursable or billable depending on your insurance coverage. Please check with your insurance plan for questions about coverage.

If you complete these forms after our appointment and I'm busy with another patient, you can leave them outside my office, on the clipboard, with the forms turned down.

Thank you,

David Goldstrom

110 Allens Creek Road, Rochester, NY 14618
Phone: 585.473.2671 Fax: 844.267.5857 Website: www.davidgoldstrom.com

Insurance Information and Assignment

Insurance Information: Primary Insured (if being used)

Insurance Company	*Name*			*Address*					
City		State		Zip		Phone	( ) -		
Subscriber ID		Group #		Policy #					
Subscriber Name	*"Same" if same as client*								
Subscriber Address	*City, State, Zip; "Same if same as client*								
Sex	☐ M ☐ F	DOB		Relation to Client		Co-Pay			

Financially Responsible Party (Who should be billed for any balances? Write "same" if same as client)

Name	*First*	*MI*	*Last*				
Address					Apt#		
City		State		Zip		Phone	( ) -

Insurance Information: Secondary Insurance (if any)

Insurance	*Name*			*Address*					
City		State		Zip		Phone	( ) -		
Subscriber ID		Group #		Policy #					
Subscriber Name	*"Same" if same as client*								
Subscriber Address	*City, State, Zip; "Same if same as client*								
Sex	☐ M ☐ F	DOB		Relation to Client		Co-Pay			

Client (or Guardian): Read, sign, and date **all** sections

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Insurance Information and Assignment

Release of Information	I authorize David Goldstrom, DMin, LMFT to release any medical or other information necessary to process insurance claims to his billing service and to the insurance companies and/or case management organizations that are providing my mental health insurance. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
	Signed: _____	Date: _____
Assignment of Benefits	I authorize payment of all medical benefits directly to David Goldstrom, DMin, LMFT.	
	Signed: _____	Date: _____
Patient's Responsibility for Payment	I understand that I am responsible for payment for services that are not covered by my insurance plan for whatever reason, including denial of medical necessity, late cancellations, missed appointments, same day/same charge duplication by different providers, etc. I also understand that if my balance is not paid in a timely fashion, I may liable for additional charges, such as interest, collection fees, etc.	
	Signed: _____	Date: _____

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