

Barnum Counseling (Kane County Counseling Services, LLC)

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Unit 2120
Saint Charles IL 60174
(630) 797-9192
(877) 881-8934

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www.barnumcounseling.com

Client Name: _____ Date of Birth (DOB): _____

Primary Insurance

Insurance Company: _____ Phone Number: _____

Address: _____

Employer/Plan Name: _____ Phone Number: _____

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

I.D. Number: _____ Group Number: _____

Secondary Insurance (if applicable)

Insurance Company: _____ Phone Number: _____

Address: _____

Employer/Plan Name: _____ Phone Number: _____

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

I.D. Number: _____ Group Number: _____

1. I give Barnum Counseling (Kane County Counseling Services, LLC) permission to release my name, date of birth, mental health diagnosis, treatment plan, date of service, and service type received from Barnum Counseling only as required by my insurance company in order to process my claim.

2. I understand that I have a right to review the information to be released. I understand that signing this form is not a required condition of receiving services from Barnum Counseling – that self-pay options outside of insurance are also available.

3. I understand that Barnum Counseling will submit a mental health diagnosis (from the Diagnostic and Statistical Manual, 5th edition) for the person identified as the patient on the insurance claim form.

4. This authorization to release information expires (one year from today): _____

Client Signature (age 12+): _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

You have the right to withdraw this release in writing at any time.