Client Billing Information
Stoner Counseling Services, LLC
Stoner Counseling.com
StonerCounselingLLC@Hushmail.com

The following is required from you (my client) and from the person who has insurance coverage (the policy holder) in order for Stoner Counseling Services, LLC and my insurance billing company to bill and receive payment from your health insurance.

Client Information

Legal name *(first, MI, last)*:	
Birthdate *(mm/dd/yyyy):*	
Social Security Number:	
Mailing address line 1:	
Mailing address line 2:	
Home or cell phone:	

Insurance Policy Holder Information

If the policy holder and client are the same person check this box. => =>	

Name (first, MI, last):	
Social Security Number:	
Birthdate *(mm/dd/yyyy):*:	
Mailing address line 1:	
Mailing address line 2:	
Home or cell phone:	
Employer (that sponsors the coverage):	

Insurance Information

Insurance Name:	
Plan #:	
Group number:	
Phone number::	

Mailing address line 2:	
Home or cell phone:	
Copay amount:	
If TriCare, TriWest or Veterans Administration we must have your **Department of Defense (DoD) Benefits Number (DBN):**	

Secondary Insurance (to be completed if you have additional insurance)

Insurance Name:	
Plan #:	
Group number:	
Phone number:	

Client Attestation

Initial each statement on the right	**Initials**
I authorize my insurance company to send payments directly to Stoner Counseling Services, LLC, and or William (Bill) Stoner, MA, LMHC.	
I accept full responsibility independent of my insurance and agree to pay all co-payments, deductibles, and balances due.	
I authorize the release of any relevant information to my insurance company that will assist in the payment of insurance claims.	
I agree to promptly notify Stoner Counseling Services, LLC if there is any change regarding my insurance coverage or my personal identifying information.	

Printed client name:	
Client signature:	
Date Signed:	

Date this form was updated: 8/30/2023.