PATIENT INFORMATION **PROVIDER**_____ **DX**_____

First Name | Middle Initial | Last Name

Address | City | State/Zip | Home Phone:

Date of Birth | Sex: M F | Social Security Number

Employer: | Work Phone | Responsible Party (name & phone)

INSURANCE INFORMATION

Insurance Name | Mailing address for claims:

Phone Number: (required for benefit verification) | Subscriber Name, relationship, date of birth, Social Security number

Identification Numbers (We must have all numbers to process claims) | Group/Employer

Secondary insurance | Subscriber | ID Numbers | Address

**** We also offer the opportunity to use MasterCard/Visa or Discover if you prefer.**

TREATMENT CONSENT: I consent to treatment as agreed upon with my therapist. I understand my patient rights and that I may receive a copy of these rights upon request.

I understand that any copayment and/or deductible determined by my insurance policy is my personal responsibility, assuming that my insurance carrier covers any portion of the bill. I further understand that I am personally responsible for payment of any amount not covered by my insurance for any reason. I am also aware that there may be a charge for a late cancellation or a missed appointment which will not and cannot be billed to insurance.

I HAVE READ THE ABOVE INFORMATION AND I AGREE

Signature – Patient or Responsible Party | Date

BENEFIT VERIFICATION

Benefits: In Net

Benefits: Out of Net

Claims Address

Deductible | Precert required: Y N | Phone # for precert dept.

Verified by: | Contact Person | Date:

This verification does not guarantee coverage. The benefits indicated above are the basic benefits of your insurance policy. Benefits will be determined at the time the claim is received and are payable under your policy assuming they are medically necessary based on your policy guidelines. For additional information contact your insurance carrier or policy handbook.