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INSURANCE INFORMATION

Patient's Name: _____

(First) (MI) (Last)

Patient's Birth Date: ____/____/____ Patient's Gender: ____ Male ____ Female

Patient's Address: _____ City: _____ Zip: _____

Patient's Phone: (_____) _____ Work: (_____) _____

Patient's Marital Status: _____Single _____Married _____Other:_____

Patient's Occupational Status: _____Employed _____ Full-time Student _____Other:_____

Please Note: "Policy Holder" refers to the name of the person who holds the insurance plan.

Patient's relationship to the policy holder: ___Self ___Spouse ___Child ___Other: _____

Policy Holder Name: _____

(First) (Last)

Policy Holder's Address: _____

Policy Holder's Phone: (_____) _____ Work: (_____) _____

Policy Holder's Birth Date: ____/____/____ Gender of Policy Holder: _____Male _____ Female

Name of Insurance Company: _____

Policy Holder's ID #: _____ Policy Holder's SS#: _____

Group #:_____ Policy Holder's Employer: _____

Name or Type of Plan: ____ PPO ____ Indemnity ____HMO ____EAP Other: _____

Phone number for verification of benefits/eligibility: (_____) _____

Address to send billing: _____

Does your insurance plan cover mental health treatment with a psychiatrist? _____ No _____Yes

What are your out of network benefits, or what percentage of the fee will your insurance cover? _____