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INSURANCE INFORMATION

Patient's Name: _____ Date of Birth: _____

Name of your Insurance Carrier: _____
Do you have an: HMO _____ PPO _____ EAP _____

Member ID Number: _____ Group Number: _____

If you have an HMO: have you received authorization to see me? Yes __No __
If you have an EAP: Have you received authorization to see me? Yes __ No __
How many sessions were you given authorization for? _____
Authorization number you were given _____
If you have a PPO: have you paid your deductible? Yes __ No __ (If not, you may be responsible for 100% payment of therapy services)

Primary Insured's Name: _____
Primary Insured's Employer: _____
Primary Insured's Date of Birth: _____
Primary Insured's Address: _____
Primary Insured's Primary Contact Number: _____
How are you related to the Primary Insured? _____
Name and date of birth of other family members covered under this same insurance:
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

What is your co-pay for a visit to a "specialist"? _____

How were you referred to me? _____

IF YOU DO NOT HAVE INSURANCE, OR DO NOT CHOOSE TO UTILIZE YOUR INSURANCE:

Agreed fee per session: _____

I understand that I am responsible for any copays and session fees, which are due **at the time of service**. I also understand that I may be responsible for 100% of total fees due if my deductible, if applicable, has not been met.

_____ _____
(Financially Responsible Party's Name) *(Date)*

_____
(Financially Responsible Party's Signature)