INSURANCE INFORMATION

If you would like me to bill your insurance company, the following information will be required:

Patient's full name _____
Patient's date of birth _____

Primary Insurance
Insurance Company_____Phone_____
Name of Insured _____
Insured's Employer_____
DOB _____ ID # _____
Group# _____

Secondary Insurance
Insurance Company_____Phone_____
Name of Insured _____
Insured's Employer_____
DOB _____ ID # _____
Group# _____

I authorize the release of any medical information necessary to process these claims. I authorize medical benefits to be paid to Ryan D. Kuehlthau, Psy.D. I understand that I will be billed for any unpaid balance beyond what my insurance covers.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

Date _____