Sarah Horvath, LCSW

800 Hwy 290 West Building A Suite 300 Dripping Springs TX. 78620 512-625-4101 Fax 512-858-9001
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Office Space only DX_____________________________________

In the event we file your insurance claim, by signing below, you authorize the release of medical information requested by the insurance company and you authorize payment of insurance benefits directly to Sarah Horvath, LCSW

Signature__________________________________ **Relationship to client**____________________ **Date**___________

Client (Adult or Child)____DOB____________Age__________

Address____

Client Phone: Home____________________ Cell ____________________ SS#______________________

Occupation/Student_________________Employment/School___________________DL#_________________

Household Members: Name M/F Relationship to client Date of birth/Age

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Parent/Guardian information if applicable:

Father name_________________________ Home______________________Cell________________________

Father's Address____ ____

Father SS#______________________DOB_______________Age____DL#____________________________

Mother name_________________________Home_____________________Cell__________________________

Mother'sAddress________________________ ____

Mother's SS#_______________ _____DOB_______________Age____DL #____________________________

Emergency Contact_____________________________Phone___________________Relationship____________

Person responsible for payment:____________________________Relationship___________________________

Address____

Phone ______________________SS#_____________________DL#___________________DOB___________

Primary Insurance_________________ID#____________________________Group#____________________

Policy holder Name______________________________________Relationship__________________________

Policy holder's Address____

Phone_____________________SS#_____________________DL#____________________DOB_________

Is there another health plan? _________If so, please indicate plan ID#/Group#/Policy:

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A COPY OF YOUR INSURANCE AND DRIVERS LICENSE IS REQUIRED

Office use only:

Authorization#________________________ Co-Pay_________________________Co-insurance_______________________

Deductible individual________________Family________________________ Visit limit_________Lifetime max_________

Out of pocket ind________________________Family________________________ Fiscal Year_________________________

Private Pay_____________________________ Contract Rate___________________________ Multi-Plan_________________