Dr. Jacquelyn M. Harlan, LMFT
License #: 89995
9550 Warner Ave., Ste. 250-08
Fountain Valley, CA 92708
(714) 403-4166

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 paid your deductible? Yes __ No __ (If not, you may be responsible for 100% payment of therapy services)
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: You may be responsible for 100% payment of therapy services if I am not an in-network provider

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 "Primary Care" visit? _____

How were you referred to me? _____

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

Agreed fee per session: __$200/session_____

I understand that I am responsible for any copays, session fees, or missed session fees; these fees are due **at the time of service**. I also understand that I may be responsible for 100% of total fees due if my deductible has not been met, if I am covered by a PPO insurance that is not contracted with Dr. Jacquelyn M. Harlan, LMFT, or if I choose not to utilize my insurance to cover psychotherapy sessions.

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

_____
(Financially Responsible Party's Signature)