INSURANCE INFORMATION FORM

	CLIENT	INSURED
Name		
Birth Date		
Policy #		
Home Phone		
Work Phone		
Cell Phone		
Address		

Employer Name ______________________

Ins Co Name ______________________

Ins Co Phone # ______________ Group # ______________ Plan# ______________

NOTE: Please sign both boxes below. Your signatures will be kept on file for insurance purposes.

CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE: *I authorize the release of any medical or other information* to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed ______________________

Dated ______________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed ______________________

Dated ______________________

PLEASE PROVIDE THE OFFICE WITH A COPY OF YOUR INSURANCE CARD

OFFICE USE ONLY

Therapist Name ______________________

Client Diagnosis ______________________

Plan Type PPO POS EPO HMO OTHER:

Bio Based Illness Under Major Medical Yes No

Benfits Reported Mental Health Major Medical

Network Reported In Out

Date Ins Yr begins ______________________

Authorization Required Yes No Client Therapist

Authorization Provided ______________________

Provider Qual: ______________________

Deductible ______________________

Deduct Remaining ______________________

Allowed Charge Usual & Customary Other: ______________________

% Pd on Allowed ______________________

CoPayment ______________________

Number of Sessions Allowed ______________________

Max Pymt Annual / Life ______________________

Ins Billing Address ______________________

CPT Allowed

90801	Yes	No
90806	Yes	No
90846	Yes	No
90847	Yes	No
96100	Yes	No

Excluded Diagnosis

313.81 Child Behavior	Yes	No
314.01 ADHD	Yes	No

Notes: ______________________