

INSURANCE INFORMATION

DID YOU CALL FOR PREAUTHORIZATION? NO _____ YES _____

PREAUTHORIZATION NUMBER: _____

MANY INSURANCE COMPANIES REQUIRE PREAUTHORIZATION FOR MENTAL AND BEHAVIORAL HEALTH SERVICES. IF THIS IS REQUIRED BY YOUR INSURANCE CARRIER AND YOU DID NOT CALL, BE AWARE THAT YOU MAY BE PENALIZED WITH DENIAL OR REDUCTION OF BENEFITS.

We will gladly file your insurance for you as a courtesy. However, we must have **full** insurance information completed below. It is up to the client to know his/her insurance coverage, including knowledge of copayment amounts and yearly deductibles. We cannot verify this information for you. If payment of the bill has not been satisfied by the insurance company within **90** days, it is the responsibility of the client or guardian to pay the bill in full. **We will not wait for secondary insurance to pay the balance. Also, copayments of what insurance is know not to pay must be made at appointment time.**

Client's Name: _____

Client's relationship to insured: _____

Client's status: Single _____ Employed _____
 Married _____ Full time student _____
 Other _____ Part time student _____

Insured's Name: _____

Insured's Address: _____

City _____ **State** _____ **Zip** _____

Insured's ID# (Social Security Number) _____

Insured's Sex: Male: _____ Female: _____

Insured's Date of Birth: _____

Insured's Employer Name or School Name: _____

PRIMARY INSURANCE COMPANY: _____

Address (where to mail claim form): _____

City _____ **State** _____ **Zip** _____

Policy or Group Name or Number: _____

SECONDARY INSURANCE COMPANY: _____

Insured's Name: _____

Insured's Address: _____

City _____ **State** _____ **Zip** _____

Insured's ID# (Social Security Number) _____

Insured's Sex: Male: _____ Female: _____

Insured's Date of Birth: _____

Insured's Employer Name or School Name: _____

Insurance Company Address: _____

City _____ **State** _____ **Zip** _____

Policy or Group Name or Number _____