INSURANCE INFORMATION

IF YOU ARE CHOOSING TO UTILIZE YOUR INSURANCE COVERAGE PLEASE FILL OUT THE FOLLOWING INFORMATION:

DATE OF BIRTH_____

SOCIAL SECURITY NUMBER _____

NAME OF INSURANCE COMPANY _____

BILLING ADDRESS _____

PHONE NUMBER FOR PROVIDERS (_____)_____

IS IT A PPO OR HMO? _____

POLICY #_____ GROUP #_____PLAN #_____

WHAT IS YOUR DEDUCTIBLE AND HAVE YOU MET IT? YES / NO / DON'T KNOW

EFFECTIVE DATE:_____/_____/_____

FOR OFFICE USE ONLY

NUMBER OF SESSIONS PER YEAR:_____

NUMBER OF SESSIONS IN A LIFE TIME:_____

ALLOWABLE CHARGE $_____

DO THEY CONSIDER A PARITY DIAGNOSIS?_____

COVERAGE PER SESSION:$_____/_____%

ALLOWABLE CO-PAYMENT:$_____