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My Billing Company Must Have All of the Following Information In Order to Submit Claims on Your Behalf to Your Insurance Company:

Name of Primary Insured: ________________________________

Social Security No: ___________________________ D.O.B. of Primary Insured: ________________________
Of Primary Insured

Telephone Number & Address of Primary Insured: (____) ________________

_______________________________________(City)___________________(State)___________(Zip)___________

If Patient is a Dependent and not the Primary Insured Please Also Complete:

Patient Social Security No: ________________________ D.O.B. of Patient: _______________________________

Telephone Number of Patient (if different): (______)___________________________

Address of Patient (if different): ____

Insurance Information (found on your insurance card)

Insurance Co Name: _____________________________

Address to file claims: __________________________________ City/State: ________________________

Zip: __________ Telephone: _________________________________

Subscriber ID of Primary Insured: __________________________ Plan/Group #: ___________________

I hereby authorize the release of any medical information necessary to process this insurance claim. I understand that I am financially responsible for the payment at the time of service and that the session information is being submitted to my insurance company as a courtesy. My insurance company will reimburse me directly and any disagreement of reimbursement of benefits is between my insurance company and myself.

Client Signature: ____ **Date:** ___________________