Sarah F. C. Allen, Psy.D., L.C.P.C. _____
3400 Dundee Rd., Suite 245, Telephone: (847) 791-7722
Northbrook, IL 60062 Fax: (847) 562-9352

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: _____