

 **Dr. Sarah Allen Counseling** 

**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:** \_\_\_\_\_