PRIVATE INSURANCE INFORMATION
PATIENT FORM

Date: ________________________ ________ Phone:______________________

Patient: ____________________________ __ DOB:_______________________

Social Security #: _______________________

Have you been seen here before: Yes No

Referring Physician: ________________________ Diagnosis: ___________________

PRIMARY INSURANCE CO. ____

Policy Holder's Name: ____

DOB: _____________________________ SS#:________________________________

Phone Number: _____________________ Relationship: ________________________

Employer: ____

ID#: ________________________________ Group ID# ________________________

Deductible Amount In Network: ___________ Out of Network ___________________
Deductible Met: In Network: ___________ Out of Network: __________________
Policy Limits for Number of Mental Health Visits:_______________________________

Does Policy require pre-certification for Mental Health: Yes / No

SECONDARY INSURANCE CO.____________ Phone Number: _________________
Policy Holder's Name: __________________ DOB: _________ SS#: _______________
Relationship: __________________________

Employer: __________________ ID#: _______________ Group #:________________

Does policy require pre-certification for Mental Health: Yes / No

Information for Pre-Certification: ____

We cannot guarantee payment for services. The patient is responsible for any unpaid balances. Insurance payments are based on medical necessity, even if coverage is 100%.

________________________________ ________________________________
Patient or Parent Date