Insurance Information

Patient Information

NAME: (as appears on ins. card) _____ DATE:_____
(Last, First, MI)

IF MINOR, PARENT OR GUARDIAN: _____

ADDRESS: _____

CITY, STATE, ZIP: _____CELL: _____

HOME PHONE: _____ WORK PHONE: _____

BIRTH DATE: ____/____/____ SEX:(Circle one) M or F

MARITAL STATUS: (Circle One) S, M, D, W, Sep. SOC. SEC. #: _____

EMPLOYER: _____

EMP. STATUS: (Circle One) F.T., P.T., Unemp., Ret. If retired, date effective: _____

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Insurance Information

INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

NAME OF POLICY HOLDER: (as appears on ins. card) _____
(Last, First, MI)

RELATIONSHIP TO POLICY HOLDER: (Self, Spouse, Child, Other) _____

IF POLICY HOLDER IS **NOT** THE PATIENT, PLEASE COMPLETE INFORMATION BELOW:

POLICY HOLDER'S ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

BIRTH DATE: ____/____/____ SEX:(Circle one) M or F

SOC. SEC. #: _____

NAME OF EMPLOYER: _____

STATUS: FT, PT, Unemp., Retired

PLEASE MAKE SURE TO SIGN BOTTOM OF PAGE 2
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SECONDARY INSURANCE – Please fill out this section only if you have secondary insurance, however PLEASE SIGN BELOW REGARDLESS OF WHETHER OR NOT YOU HAVE SECONDARY INSURANCE.

SECONDARY INSURANCE COMPANY: ______________________________

POLICY #: ____________________ GROUP #: ____________________

NAME OF POLICY HOLDER:(as appears on ins. card) ____________________________
(Last, First, MI)

RELATIONSHIP TO POLICY HOLDER: (Self, Spouse, Child, Other) ____________________

IF POLICY HOLDER IS **NOT** THE PATIENT, PLEASE COMPLETE INFORMATION BELOW:

POLICY HOLDER'S ADDRESS: ________________________

CITY, STATE, ZIP: __________________________________

HOME PHONE: ______________ WORK PHONE: __________

BIRTH DATE: _____/_____/_____ SEX: M or F (Circle one)

SOC. SEC. #: ________________

NAME OF EMPLOYER: ______________________________

STATUS: FT, PT, Unemp., Retired

I hereby authorize and request my insurance company to pay directly to Clare A. Stadlen, LCSW, PLLC, the amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the nature of the disability and or procedure be such that it is not covered by the policy, I will be responsible to for payment of the entire bill.

____ __________

Patient's Signature **Date**

____ __________

Policy Holder's Signature **Date**

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FOR OFFICE USE ONLY

*Deductible amt.: __________(family or individual?) *Amount used already: __________

*Max # of visits/amt.: ______________ *Patient copay amount: ________________

*CPT codes/services covered/not covered: ________________________________

*Pre-authorization instructions: ____________________________________

*Billing address: ____

*Dx: I _____________________ III_______________________

II_____________________ IV_______________________

*Ref. Physician & NPI #: __________________ Date last seen: ______________
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