INSURANCE AND FINANCIAL INFORMATION

Patient Name: _____ Soc Sec #: _____
(Last) (First) (M.I.)

Primary Insured: _____ **Date of Birth**: _____
(Last) (First) (M.I.)

Circle One **IF** Insured is other than self: Parent Spouse Partner Child SSN:

***If* different from Intake/Patient Information:**

R/P Address: _____
(Street) (City) (State) (ZIP)

Mailing Address: _____

Phone: _____
(Home) (Work) (Cell)

Age: _____ Birth date: _____ M / F Relationship to Patient: _____

Emergency Contact/Phone: _____

Primary Insurance Coverage(*If not copied)*: _____

Name of Insured: _____ Effective Date: _____

Group Number: _____

Policy Number: _____

Phone: _____ Authorization Phone: _____

Authorizing Info: _____

NOTE:

Your Insurance will almost certainly be disappointing. They often pay something. They rarely pay what it seems like they will in the beginning, even if it seems that way because they said it. I will make a good faith effort to collect funds from your Insurance, but please note the first sentence above: your Insurance will almost certainly be disappointing and we may need to arrange a payment agreement.

Release of Information and Assignment:

I certify the above information is correct. I understand this information will be used in applying for payment of charges and authorize Paul Gessford MFT or agent to release information required by my insurance company for the purposes of processing my insurance claim. I understand there is no guarantee of payment from any insurance company and acknowledge I am financially responsible for charges not paid by insurance. I authorize payment of benefits directly to Paul Gessford MFT for services provided.

Signature: _____ Date: _____
(Patient / Legal Guardian / Responsible Party)

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