Date:_____

Insurance Billing Form

Client: _____ Phone:_____
Last First MI

SSN: _____DOB:_____ Gender: _____M_____F

Address:_____
Street/PO Box Apt #

_____ _____ _____
City State Zip

Responsible Party (If other than client)

Name:_____ DOB:_____

Relationship to Client: _____ SSN:_____

Mailing Address:_____
Street/PO Box Apt #

_____ _____ _____
City State Zip

Primary Insurance

Policy Holder:_____ DOB:_____
Last First MI

Insurance Company:_____ ID#:_____

Group #:_____ Insurance Phone#:_____

Secondary Insurance

Policy Holder:_____ DOB:_____
Last First MI

Insurance Company: _____ ID#: _____

Group #:_____ Insurance Phone#:_____

I understand I am responsible for all charges incurred, regardless of insurance status. I agree to pay for services as they are provided and/or pay promptly upon receipt of a statement. I acknowledge the above information is correct. I authorize my insurance company(s) to pay my therapist, _____, for services filed on my behalf. This assignment will remain in effect until revoked by me in writing.

Signature: _____ Date:_____