Insurance Information
(Complete if you wish to use your health insurance to pay for services.)

Date: ________________________________
Client's Name: ____

Insurance Provider Information
Company Name: ____
Plan Name: ____
Address: ____
____
Phone: ____

Client's Insurance Policy Information
ID Number: ____
Group Number: ____
Deductible Amount: ____
Portion of Deductible Met for This Year (if known): ________________________

Insured's Information (if different than Client's)
Client's Relationship to Insured: ____
Name: ____
Gender (circle): Male Female
Address: ____
____
DOB: ____
Social Security #: ____
ID Number: ____
Group Number: ____
Employer: ____

Office Policies on Insurance Billing

Due to the complexities and time delays of insurance reimbursements, this office requires that each session be paid in full at the time of service. If a patient wishes to utilize his or her health insurance for reimbursement, this office will bill your insurance company for you on a monthly basis at no charge. Reimbursement will be sent directly to the patient by the insurance company. Any necessary follow-up with the insurance company regarding claim status is the responsibility of the patient. As a reminder, if the insurance coverage includes an annual deductible, the patient will begin to receive reimbursement after the deductible has been met. Insurance cannot be billed for no-shows or late cancellations (less than 24 hours notice). Under such circumstances, the patient will be responsible for payment of the full fee for the missed therapy session.

I have completed this form truthfully and accurately. I hereby authorize Dr. Brooke Bucellato, Psy.D., to bill my insurance company for psychotherapy services. I have read and understood the Office Policies on Insurance Billing and agree to abide by them, unless other arrangements aremade.

Signature: _______________________________________ Date: _____________________
(Client)

Signature: ____ Date:_____________________
(Insured)