INSURANCE INFORMATION SHEET

It is important that you thoroughly complete this form and provide a copy of both sides of your insurance card(s). Thank you.

Therapist's Name: _____

CLIENT INFORMATION

Name: _____Birth Date: _____

Address: _____SS#: _____

City: _____State: _____Zip:_____

Home Phone: _____Mobile Phone:_____Employer:_____

Is client a dependent child? Yes or No Martial Status: (Cirlce one) M S Other

PRIMARY INSURANCE INFORMATION

Who is the Insured: _____SS#: _____Birth Date:_____

Employer of Insured: _____Work Phone:_____

Insurance Co.: _____Policy #: _____Group #:_____

Customer Service Phone: _____ Mental Health Phone: _____

DO YOU HAVE SECONDARY INSURANCE? Yes or no

Who is the Insured: _____ SS#: _____Birth Date:_____

Employer of Insured: _____ Work Phone: _____

Insurance Co.: _____Policy #: _____Group #: _____

Customer Service Phone: _____ Mental Health Phone: _____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that Charu Chandra, LCPC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold Charu Chandra, LCPC liable for insurance nonpayment due to misquoted benefits. I acknowledge I am responsible to know and understand my benefits plan. Charu Chandra, LCPC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request assigned benefits be paid to Charu Chandra, LCPC and/or the provider indicated above.

Signature of Client and/or Insured:_____ Date:_____