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, I must ask that you pay in full (that is, your co-pay plus what you anticipate your insurance will pay) at each session. Insurance reimbursement will then be sent directly to you by your insurance provider.

- Insurance billing shall occur monthly at no charge to you.

- Any necessary follow-up with your insurance provider regarding claim status, etc. is your responsibility.

- As a reminder, if your insurance plan has a deductible, you will begin receiving reimbursements after the deductible has been met.

- Insurance cannot be billed for no-shows or late cancellations (less than 24 hours notice). Under such circumstances, you will be responsible for full payment of your fee.

I have completed this form truthfully and accurately. I hereby authorize Emily R. Gombos, M.A., LMFT to bill my insurance provider for psychotherapy services. I have read and understood the Office Policies on Insurance Billing and agree to abide by them, unless other arrangements are made.

Signature: _____ Date: _____
(Client)

Signature: _____ Date: _____
(Insured)