INSURANCE AUTHORIZATION/PAYMENT FORM

Client's Name:_____ DOB:_____ SSN: _____

Insurance Company: _____

Insurance ID Number:_____ Group Number: _____

Policy Holder's Name:_____ DOB: _____

Policy Holder's Place of Employment: _____

Is Pre-Authorization Required ☐ Yes ☐ No

Pre-Authorization Number: _____

From:_____ To: _____For _____ Visits

Does Your Insurance Have a Deductible: _____ Has It Been Met: ☐ Yes ☐ No
Insurance Co-Payment Amount: _____
Does Your Insurance Require you to Pay a Co-Insurance: ☐ Yes ☐ No

Appt Date & Time:_____ Therapist:_____