

# 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: \_\_\_\_\_