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. Lisa Schenitzki, 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 are made.

Signature: _____ Date: _____
(Client)

Signature: _____ Date:_____
(Insured)