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INSURANCE INFORMATION

Please provide a photocopy—both front and back--of your insurance card. If the information requested below is on the insurance card, then you do not need to fill in the information below. Please do provide any additional information not on your card requested below.

Name of Insurance Company: _____
Name of Policy Holder: _____
Relationship to Patient: Self_____, Spouse_____, Parent_____, Other_____
I D # _____
Group Name (usually the name of your employer): _____
Group Number: _____
Mailing Address for Claims:
Name: _____
Street/P.O. Box: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____

Authorization # _____

Co-pay for First Session _____

Co-pay for Additional Sessions_____

Deductible Amount Remaining _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Maidena A. McLerran, Ph.D. to release to my Insurance Company(s) including but not limited to Aetna, Magellan Health and affiliates, Project Concern EPA, United Behavioral Health, U. S. Behavioral Health Service, Victim Witness, any information about myself or my dependents necessary to process my insurance claim(s). I agree this authorization shall be valid while my claim(s) are pending.

Printed Name _____ **Date**_____

Signature _____