FOR OFFICE USE ONLY
DX:_____

HARMONIA: MADISON CENTER FOR PSYCHOTHERAPY, L.L.C.
INSURANCE COVERAGE INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTERIES										
Patient Name (Last Name, First, MI)			Date of Birth		Age	Marital Status.		Today's Date		
Address (Street)		City		State	Zip		Home Phone			
Employer's Name		Address (Street)			City		State	Zip		
Occupation			Social Security Number (optional)				Work Phone			
Spouse's Name (Last, First, MI)			Date of Birth		Social Security Number			Spouse's Work Phone		
Emergency Contact who does not live with you				Relationship				Phone Number		
Who is responsible for this bill?		Address			City		State	Zip		

I. If both spouses in a household carry health insurance, the primary policy is the one in **your name.** Your spouse's insurance if it covers you, is secondary.

I. II. If the client is a minor child who; is covered as a dependant on both parents' insurance, the parent whose birth date comes earlier in the calendar year is **primary** and the other parent's insurance is secondary

INSURANCE INFORMATION					
Primary Insurance Name	Address (Street – City – State – Zip)			Phone	
Name of Insured	Relationship	ID Number		Group Number	
Secondary Insurance Name	Address (Street – City – State – Zip)			Phone	
Name of Insured	Relationship	ID Number		Group Number	

I UNDERSTAND THAT FOR INSURANCE BILLING PURPOSES, YOU MAY RELEASE THE FOLLOWING PATIENT HEALTH INFORMATION: NAME, ADDRESS, SOCIAL SECURITY NUMBER, POLICY NUMBERS, DIAGNOSIS, PROCEDURE CODES AND DATES OF SERVICE.

I HEREBY AUTHORIZE THE ABOVE INSURANCE COMPANY/COMPANIES TO MAKE PAYMENTS DIRECTLY TO THE PROVIDER FOR THE BENEFITS HEREIN AND OTHERWISE PAYABLE TO ME. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

_____ _____

(Signature) (Date)

Over