

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
<p>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.</p> <p>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</p>					

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)