Insurance Billing Form

Is Authorization needed from your insurance company? YES NO
Yearly deductible $ _____ Deductible met this year $_____ Copay per service $_____
Authorization # _____ Number of Visits Granted _____
[ ] My psychotherapy sessions will go towards my deductible (which means I will pay for these services until my deductible is met)
OR
[ ] These services will be paid by my insurance company, minus any co-payment or co-insurance amount that I will owe.

All payments are due in full at time of service, via check or cash.

PATIENT NAME (last, first, m.i.)		**Physical Address:**	
Mailing Address (If Different)			
PATIENT INSURANCE ID NUMBER	**INSURANCE COMPANY**		**PATIENT DATE of BIRTH**
SUBSCRIBER'S NAME (Last, first, m.i.)	**EMPLOYER**	**MARITAL STATUS** **M S W D**	**SUBCRIBER'S DATE of BIRTH**
RELATIONSHIP to SUBSCRIBER **Self Partner Child**	**MARITAL STATUS** **M S W D**	**DAYTIME PHONE**	**Group #**
MY INSURANCE COMPANY HAS VERIFIED THE INFORMATION I AM PROVIDING **PATIENT SIGNATURE and DATE** **X**		**MY INSURANCE COMPANY HAS VERIFIED THE INFORMATION I AM PROVIDING** **PARENT SIGNATURE (if PATIENT is a MINOR) and DATE** **X**	

Therapist Use Only Below this Line _____

90801 _____ Diagnostic Exam/ Intake (45 min is paid for by insurance company)

90837 _____ Individual Therapy (one hour is paid for by insurance company)

90847 _____ Couples /Family Therapy (45 min paid for by insurance company)

SERVICE DATE _____ **DSM-V** _____

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