CENTER FOR ANXIETY RELIEF AND EDUCATION, PLLC

Insurance Form

(Please initial)

_____It is the client's responsibility to inform us of whether his/her deductible has been met.

_____Any amount not covered by the client's insurance is the client's responsibility.

_____Out of Network (OON) clients are expected to pay agreed upon fee in total and will be responsible for submitting claims to his/her insurance company for reimbursement. (Therapist is responsible for providing the client with pertinent details that will help facilitate a smooth claim process.)

_____Out of pocket (OOP) expenses are due on the day of service. All balances must be up to date prior to scheduling future appointments.

_____ _____

Client Name Person Responsible for bill (or Self)

Is this client covered by insurance? YES _____ NO _____

_____

Primary Insurance

_____ ___/____/_____

Policyholder Name Policyholder Birth Date

_____

Address of policyholder **(if different from client address)**

_____ $_____

Phone number of policyholder Co-pay / Co-Insurance

_____ _____

Policy Number Group Number

_____ _____

Policyholder's Employer Client's Relationship to Policyholder

_____

Secondary Insurance (provide pertinent details related to this policy if applicable)

I verify that the above information is correct, and that I understand and accept information regarding responsibility for payment of services.

_____ _____

Client Signature Date