Riverwalk Psychotherapy Associates, LLC

Therapist Initials: _____

Fee: _____

PP: _____ INS: _____

DX: _____

INSURANCE COVERAGE INFORMATION

(PLEASE COMPLETE ALL SECTIONS)

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First MI)	Date of Birth ___/___/___	Age	Marital Status	Today's Date ___/___/___

Address (Street – City – State)	(Zip)	Home Phone (_____) _____-_____
Employer Name	Work Phone (_____) _____-_____	Cell Phone (_____) _____-_____

Employer Address (Street – City – State)	(Zip)	Occupation	Social Security No.
Spouse's Name (Last, First, MI)	DOB ___/___/___	Social Security No.	Spouse's Work Phone (_____) _____-_____
Emergency Contact who does not live with you	Relationship		(_____) _____-_____

Who is financially responsible for this bill?

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.

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	I.D. No.	Group No.
Secondary Insurance Name	Address (Street – City – State – Zip)		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. No.	Group No.

ASSIGNMENT OF BENEFITS: 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)

PLEASE COMPLETE BACK SIDE