CLIENT INSURANCE INFORMATION FORM 2011

for

Lynne Logan, Ph.D., LMFT

PLEASE PRINT:

Today's Date___________________________________ Your Birth date:____________________________

Client Full Name__________________________________ Race: (***Required by your insurance***)_________

Address:____

City:__________________________________State:__________Zip________+_______Please include the additional 4 digits of your zip code. You can find this usually on a utility bill. (***Required by your insurance***)

Phone:____

Email:____

Primary Language Spoken: (***Required by your insurance***)____

Hispanic_______ Non-Hispanic_______ (***Required by your insurance***)

Name of Insurance Co:____

Insurance ID # on your card:____

Phone Number on your insurance card (Customer Service or Mental Health):_______________________

Policy Holder Name:____

Policy Holder Birthdate:____

Your Relationship to Policy holder (check one) Self: __________Spouse: ____________Child:__________

Please read the below information and sign:

For purposes of insurance eligibility, verification, authorizations, and billing, I hereby authorize Dr. Lynne Logan, Ph.D., LMFT, to release the above required information to Electronic Claims and Specialty Systems Billing Service and it's agents, or any third party carrier as necessary to secure payment of my insurance benefits. I hereby agree I am fully responsible for any and all deductibles, co payments, or co-insurances that are not covered by my insurance company. I agree as per my signature below:

Signature of Client (if client is a minor, parent or guardian sign):

____

IMPORTANT: IF YOU HAVE A COPY OF YOUR ***INSURANCE CARD***, PLEASE BRING YOUR CARD TO YOUR FIRST VISIT. THANK YOU.