

CLIENT INSURANCE INFORMATION FORM

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***) _____

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.