Insurance Information

Patient's Name: _____

Address: _____

Date of birth: _____

Employer: _____

If patient is not the policy holder, please complete the following three lines:

Policy holder's name: _____

Policy holder's date of birth: _____

Employer: _____

Insurer: _____

Insurance ID number: _____

Group number: _____

Phone no. for mental health claims: _____

Address for mental health claims: _____

_____

Check or initial the following agreements.

_____ I give my permission for Celia Hartnett's business manager to file for out-of-network benefits with my insurer, using the information I have provided. I understand that Ms. Hartnett will provide diagnostic information to my insurer. I understand that if my policy requires I meet a deductible, I will not be reimbursed by my insurer until that deductible has been met.

_____ I understand that it is my responsibility to obtain prior authorization for psychotherapy sessions from my insurer before Ms. Hartnett's business manager will file my insurance claim for me. I am responsible for any additional information required by my insurer.