Professional Psychological Services

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INSURANCE INFROMATION

Client's Name: _____

Client's Address: _____

Client's Date of Birth: _____

Client's Gender: ☐ Male ☐ Female

Client's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Client's Employment Status: ☐ Employed ☐ Full-time student ☐ Part-time student

Client's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Insured's Name: _____

Insured's Date of Birth: _____

Insured's Gender: _____

Insured's Address: _____

Insured's Phone Number: _____

Insurance Plan/Program Name: _____

Insured's I.D. #: _____

Insured's Group/Policy #: _____

Insured's Employment: _____

Co-pay amount: _____

I certify that I have the insurance coverage named above and assign directly to Professional Psychological Services all insurance benefits. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize Professional Psychological Services to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____