SAN DIEGO
BEHAVIORAL MEDICINE

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License No. PSY20004

INSURANCE INFORMATION

Patient Name: _____
(First) (Last)

Patient's Date of Birth: _____/_____/_____ Gender of patient: Male Female

Patient's Address (stress/city/zip): _____

Patient's Phone: (_____) _____ Other (_____): _____

Patient Status: Single Married Other Employed Full-time student Disability Other
(check all that apply)

Patient's relationship to the policy holder: Self Spouse Child Other: _____

Policy Holder Name: _____
(First) (Last)

Policy Holder's Address: _____

Policy Holder's Phone: (_____) _____ Other (_____) _____

Policy Holder's Date of Birth: _____/_____/_____ Gender of Policy Holder: Male Female

Policy Holder's Employer: _____

Name of Insurance Plan or Program: _____

Policy Holder's ID #: _____ Policy Holder's SS#: _____

Group #: _____

Name or Type of Plan: PPO Indemnity HMO EAP Other: _____

Phone number for verification of benefits/eligibility (on back of card): (_____) _____

Address to send billing (on back of card): _____

Deductible: $_____ Amount already met: $_____ Co-pay: $_____

How many sessions are allowed in your plan? _____How many sessions were approved? _____

Name of Primary Care Physician: _____ Phone #: (_____) _____

Name of Referring Physician (if different from above): _____ Phone #: (_____) _____

Authorization Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to San Diego Behavioral Medicine.

Patient or authorized person's signaturea; _____

I authorize payment of medical benefits to San Diego Behavioral Medicine for services described.

Insured or authorized person's signature: _____