SHARON EILER MA. LMFT
Counseling for Individuals. Couples. Youth

INSURANCE INFORMATION FORM

If you are using insurance, you will not be eligible for a reduced fee. . All services will be charged at our usual and customary fee as noted on your service agreement. Your insurance may or may not pay a part of the cost of therapy. You will be responsible for what your insurance does not cover, including but not necessarily limited to your annual deductible, co-payment or services not authorized or covered under your policy. We will bill any secondary policy from the date information on said secondary policy is provided. It is the agency policy that if information is not provided until a later date, we will begin billing from the date information is provided only. Any retroactive secondary insurance billing will be your responsibility. **Secondary insurance plan information may be provided on the backside of this form.** **Knowingly providing false or inaccurate information may be considered insurance fraud.** **Please present your health card to your therapist so that a photocopy may be made. If you are unable to provide us with adequate information with which we can bill your health insurance, all charges will be billed directly to you.**

Medicare	Champus	ChampVA	Group Plan	FECA/Black	Other
☐	☐	☐	☐	☐	☐

Patient Information

PATIENT'S Name (Last, First, Middle Initial):	PATIENT'S Social Security #:
Address:	PATIENT'S Birthdate: Sex: ☐ Male ☐ Female
City State: Zip:	☐ Single ☐ Married ☐ Other
Telephone Number (including area code):	☐ Employed ☐ FT Student ☐ PT Student

Primary Insurance Information

INSURED'S Name (Last, First, Middle Initial):	Health Plan ID#:
Address:	Insurance Company:
City State: Zip:	Policy Plan Name:
Telephone Number (with area code):	Group Number:
INSURED'S Social Security #:	Insured's Employer (Company Name):
INSURED'S Birthdate:	Insurance Telephone Number:
Sex: ☐ Male ☐ Female	Insurance Claims Address:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Step Child ☐ Other

Is there another Health Benefit Plan? ☐ YES **(If yes, please complete backside of this form)** ☐ NO

If there are any changes to the above information, please let your therapist know as soon as possible. Use of insurance requires us to release a diagnosis to your insurance company. Some insurance companies require additional information. We cannot guarantee that information released to other parties will remain confidential.

PATIENT'S or AUTHORIZED PERSON'S SIGNATURE: I authorize the exchange of any medical or other information necessary to process this claim or to determine eligibility, including number of available sessions. I also request payment of benefits either to myself or the part who accepts assignment.	INSURED'S or AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to Sharon Eiler, MA, LMFT
Signed: ______________ Date: ________	Signed: ______________ Date: ________

Account Number:	Diagnosis:	Therapist Signature:
______________	______________	______________

Please Turn Over to Complete Secondary Insurance Information