

MENTAL HEALTH BENEFITS INFORMATION

TODAY'S DATE: _____

PLEASE USE A BLACK PEN !!!!

THIS PAGE IS REQUIRED INFORMATION: ***BRING THIS COMPLETED FORM TO 1ST SESSION***

CLIENT NAME: _____ **Age:** _____ **Sex:** _____

Date of Birth: _____ **Social Security Number:** _____

Patient Status (Circle): MARRIED SINGLE OTHER • EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT OTHER

Your Full Address: _____

Phone: _____ **Insurance I.D. #:** _____

POLICY HOLDER NAME _____ **Date of Birth:** _____

Full Address: _____

Phone: _____ **Employer Name:** _____

INSURANCE BENEFITS: Name of Insurance Company and Claims Address: _____
_____ Claims Phone: _____

EAP CLIENTS: **THE NEXT PART IS NOT REQUIRED FOR YOU**

THIS MUST BE COMPLETE: ***CALL YOUR INSURANCE COMPANY FOR SOME OF THE INFORMATION***

Are your Benefits In-Network? **Y N** Do you have a Deductible? **Y N**

What is the amount of your Deductible? _____ How much of the Deductible have you already paid? _____

Do you have a Copay? **Y N** What is the amount of your Copay? _____ Is Authorization required? **Y N**

What is your Authorization Number? _____ How many sessions are Authorized? _____

When does your Authorization begin? _____ When does your Authorization end? _____

What is the total number of sessions that your plan covers per Plan Year or per Calendar Year? _____

Is there anything else I should know about how you are paying for your sessions? _____

COPIES OF YOUR INSURANCE CARD ARE AFFIXED HERE