Gretchen White, LCSW

INSURANCE/BILLING INFORMATION

PLEASE PRINT LEGIBLY (* required information)

*Name: ____
(Last) (First) (MI)

*Home Address: ____

*City: ______________________ *State ____________ *Zip ________

Bills may be sent to this address: Yes ________ No ________

If "no", provide an alternate billing address: ______________________________

City: ______________________ State ____________ Zip ________

*SS#: ____________________ *Date of Birth: ________________

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Do you want insurance filed for you? Yes __________ No ____________

Primary Insurance Company Name: ______________________________
*Insurance Card I.D. Number ______________________________
Group Number ______________________________
*Policyholder's Name ______________________________
*Policyholder's DOB ______________________________
*Policyholder's Address ______________________________
City ________________ State ____________ Zip ________
*Client's Relationship: Self ________ Spouse ________ Child ______

Secondary Insurance Company Name: ______________________________
Insurance Card I.D. Number ______________________________
Group Number ______________________________
Policyholder's Name ______________________________
Policyholder's DOB ______________________________
Policyholder's Address ______________________________
City ________________ State ____________ Zip ________
Client's Relationship: Self _____ Spouse ________ Child ______

I authorize the release of any confidential medical information necessary to process my medical claims and for the continuation of treatment to the insurance carriers as required by them. I understand that I am required to pay any health insurance deductible, co-insurance, or any other charges incurred which are not paid by my insurers or any third party payors.

*Signature: ______________________________ *Date: ________________