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Billing Information

Please bring your insurance card (or a copy of it) to your first appointment.

Client Name: _____ DOB: _____

Gender: M F Marital Status: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

May messages be left for you at home? _____ At work? _____ Cell? _____ Email? _____

Primary Insurance Carrier: _____ Phone: _____

Claims Address: _____ City: _____ Zip: _____

Name of Insured: _____ Relation to Client: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____ Employer: _____

Insured's Address: _____ City: _____ Zip: _____

(To be completed by provider)

Deductible amount \$ _____ per person _____ per family _____ per fiscal yr _____ per calendar yr _____ per policy yr

Has deductible been met? Yes No If no, how much left? \$ _____

Benefit _____ % of _____ charges _____ usual and customary Copay/CoIns \$ _____

Limits of mental health benefit? Yes No _____ # of sessions _____ per year *or* _____ per 24 month period *or* _____

Mental health benefit currently available all *or* part If part, how much left? _____

Preauth required? Yes No Name & number of contact for preauth _____

Secondary Insurance Carrier: _____ Phone: _____

Claims Address: _____ City: _____ Zip: _____

Name of Insured: _____ Relation to Client: _____

Insured ID Number: _____ Group Number: _____

Insured DOB: _____ Phone: _____ Employer: _____

Insured's Address: _____ City: _____ Zip: _____

I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Wendy Newton, Psy.D. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Wendy Newton, Psy.D.

Signature _____ Date: _____