**Insurance Form**

Patient Name:_____ DOB _____/_____/_____

Address:_____City_____State_____Zip_____

Home Phone: (  )_____--_____ Mobile: (  )_____--_____

Can Voicemails be left at either number? Y N

E-Mail: _____

Cash Fee (*no insurance being billed*): $_____

**Insurance Information**

Subscriber Name: _____ DOB _____/_____/_____

Relationship to Patient: _____

Address:_____City_____State_____Zip_____

Carrier:

_____

Contract/Enrollee ID number: _____

Group: _____

Mailing Address: _____

Carrier Phone: (  )_____--_____ (include copy of card front & back)

**Does patient have secondary insurance? Yes No**

I authorize any clinical or other information needed for my insurance claim according to insurance policy requirements, and necessary to process as needed for billing purposes. I authorize any information needed for accounting and billing purposes. I also accept responsibility for payment of cash fees, co-pays, deductibles and non-payment of fees not paid to the provider by the insurance company. As is customary, I agree to pay my cash fee, deductible and co-payment at the time services are rendered. If no insurance coverage, I agree to pay my fee in full at each session.

Patient Signature: _____

Date: _____

Therapist Signature: _____

Date: _____

***(This form must be signed in order to bill insurance company)***

**Wolf Psychological Services PLLC**