

Client Information Sheet for Medical Billing

Doris Stabp
Tara Brown

Please complete this form **COMPLETELY**

Date: _____

Client Name (Formal Name): _____

Date of Birth: _____ Sex: Male Female Marital Status: Married Single Other

Address: _____ City, State, Zip Code _____

Email Address _____

Phone Number: Home (____) _____ Cell (____) _____ Work (____) _____

Primary Care Physician: _____ Employment: _____

Insurance Information-PLEASE FILL OUT ALL INFORMATION COMPLETELY

Primary Insured Name (Formal Name) _____ Date of Birth _____

Address if different then above _____

Phone Number of Primary Insured _____ SS# of Primary Insured _____

Email Address of Primary Insured _____ Sex: Male or Female

Marital Status of Primary Insured: Married Single Other

Insurance Company Name _____ Member ID # _____

Group # _____ Customer Service Phone Number (Back of Card) _____

Name of employer: _____ Who is financially responsible for this bill? _____

Do you have secondary insurance coverage?? YES NO

Please Fill Out Page 2-Secondary Insurance Information

Release of Information for Insurance Verification/Authorization of Benefits /Claims Processing/Fee/Payment

Please initial below

____ I authorize Doris Stabp and its subsidiaries, to check/verify insurance coverage and benefits.
____ I authorize the release of any medical or other information necessary to process claims related to services provided by Doris Stabp.

____ I authorize payment of medical benefits to Doris Stabp for services provided.

____ I understand and agree that I am financially responsible to pay for co-pay/coinsurance/deductible/other services not covered by my insurance. I assign all benefits from insurance or other third-party coverage to Doris Stabp. Further, I understand that by signing this form I acknowledge that if my insurance carrier or HMP/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Doris Stabp.

Client Signature or Authorized Person's Signature _____ Date _____

For Therapist only:

Preauthorization Number and Dates: _____

Primary Diagnosis: _____