PDX Mindful Therapy LLC

Insurance Form

Patient Name: _____ DOB: _____

Gender: M F Referred by:_____

Marital Status (circle): Married Single Divorced Widowed Partnered Separated

SSN: _____ State and Drivers License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____

Email: _____

Can I leave a phone message? Yes No
Email messages Yes No

Insurance Information - Please provide a copy of your insurance card(s), front and back.

Primary Insurance Company: _____ Phone: _____

Claims Address:_____

City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Policy Effective Date_____ Expiration:_____

Name of the primary insured individual: _____ Relation to Patient: ____

Insured DOB: _____ Phone: _____Employer: _____

Insured's Address (if different than patient's address):_____

City: _____ State: _____ Zip: _____

Please remember that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance or any other balance not paid by your insurance.

Patient or Guarantor's signature: (Please initial each line)

____I hereby authorize the release of all medical information necessary to process an insurance claim.
____I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to PDX Mindful Therapy LLC
____I hereby authorize my insurance carrier to make payments directly to PDX Mindful Therapy LLC
____I understand the financial policy established by PDX Mindful Therapy LLC
____I understand that balances left unpaid over 90 days from the date of service may be assessed late fees and if assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

_____ _____

Patient or Guarantor Signature Date