Insurance Information (BCBS PPO only)

PATIENT INFORMATION

Patient Name _____DOB____/____/_____
Last First MI

Gender (as listed with insurance company) _____ Marital Status_____

Address_____
Street City State Zip

County_____ Home Phone _____

GUARANTOR'S INFORMATION

Name of Insured _____ Relationship_____

DOB_____/_____/_____ Phone_____

Address _____
Street City State Zip

Employer Name (Required) _____

Insurance Company:

Name _____ Policy # _____ Group #_____

Customer Service Phone _____

Do you need to pre-notify insurance of Services?_____ If yes, have you?_____

Have you verified that Reflections Psychotherapy, PC/ Mindy Marx, LCSW is an In Network Provider? _____

Do you have an additional insurance policy? _____

I agree to allow Reflections Psychotherapy, P.C. to conduct all necessary communications with my insurance company for the purpose of billing and certification of services.

_____ _____
Signature (responsible person) Date