Northwest Psychological Center

INSURANCE INFORMATION

Primary

Name of Policyholder: ______________________ Date of Birth: _____________________

I.D.#: ____________________________________ Group #: _________________________

Relationship to Client: ____

Name of Insurance Company: ____

Insurance Company Phone #: ____

Secondary

Name of Policyholder: ______________________ Date of Birth: _____________________

I.D.#: ____________________________________ Group #: _________________________

Relationship to Client: ____

Name of Insurance Company: ____

Insurance Company Phone #: ____

I have completed the above information to the best of my knowledge. If any of the information changes, I will notify Northwest Psychological Center, PC as soon as possible. Otherwise, I will be held liable for any incorrect information.

By signing this form:
Northwest Psychological Center, P.C. has my permission to bill my insurance company/ies for services rendered. I authorize the release of any medical information necessary to process these claims. I authorize medical benefits to be paid directly to Northwest Psychological Center, P.C. or to the treating clinician.

____ ____________________________________

Signature of Responsible Party Date