

South Coast PSYCHIATRY

Psychotherapy & Medication Management

INSURANCE INFORMATION

Patient's Name: _____
(First) (MI) (Last)

Patient's Birth Date: ____/____/____ Patient's Gender: Male Female

Patient's Address: _____ City _____ Zip _____

Patient's Phone: (____) _____ Work (____) _____

Patient's Status: Single Married Other Employed Full-time student Other
(check all that apply)

(Please Note: "Policy Holder" refers to the name of the person who holds the insurance plan)

Patient's relationship to the policy holder: Self Spouse Child Other: _____

Policy Holder Name: _____
(First) (Last)

Policy Holder's Address: _____

Policy Holder's Phone: (____) _____ Work (____) _____

Policy Holder's Birth Date: ____/____/____ Gender of Policy Holder: Male Female

Name of Insurance Company: _____

Policy Holder's ID #: _____ Policy Holder's SS#: _____

Group #: _____ Policy Holder's Employer: _____

Name or Type of Plan: PPO Indemnity HMO EAP Other: _____

Phone number for verification of benefits/eligibility (on back of card): (____) _____

Address to send billing (on back of card): _____

Does your insurance plan cover mental health treatment with a psychiatrist? No Yes

What are your out of network benefits, or what percentage of the fee will your insurance cover? _____

How many sessions are allowed in your plan? _____ How many sessions were approved? _____