

Insurance Billing Form

Is Authorization needed from your insurance company? **YES** **NO** Authorization # _____
 Yearly deductible \$ _____ Deductible met this year \$ _____ Co-pay per mtg due \$ _____

PATIENT NAME (last, first, m.i.)		SOCIAL SECURITY #	
PATIENT Address (Subscriber Address if patient is a minor)			
PATIENT ID Number	MARITAL STATUS M S W D	DAYTIME PHONE	PATIENT DATE of BIRTH
SUBSCRIBER'S NAME (Last, first, m.i.)	EMPLOYER	SUBSCRIBER'S SSN	SUBSCRIBER'S DATE of BIRTH
RELATIONSHIP to SUBSCRIBER Self Partner Child	INSURANCE COMPANY		Group #
PATIENT SIGNATURE and DATE X		PARENT SIGNATURE (if PATEINT lis a MINOR) and DATE X	

90801 _____ Diagnostic Exam/ Intake

90847 _____ Family/ Couples Therapy

90804 _____ Individual therapy, 20-30 min.

90889 _____ Report Preparation

90806 _____ Individual Therapy, 45-50 min.

90853 _____ Group Therapy 15 min. units

90808 _____ Individual Therapy, 75-80 min.

SERVICE DATE _____

DSM-IV _____

MSGS: _____